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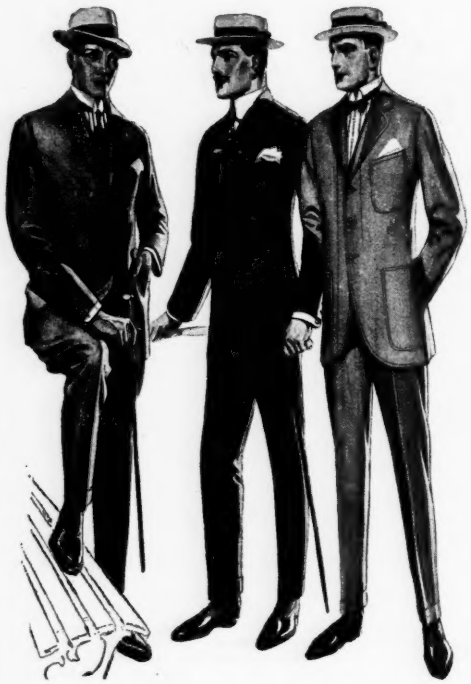

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—3RD YEAR. SYDNEY: FEBRUARY 12, 1916. No. 7.

SUSPENSION OF THE PREGNANT UTERUS IN CASES OF THREATENED OR IMMINENT ABORTION.

By **William T. Chenhall, M.D., F.R.C.S. (Ed.),**

Honorary Surgeon, Royal Hospital for Women, Sydney.

Introduction.

Spontaneous expulsion of the human ovum occurs, at least, in one of every five pregnancies. It is much more frequent among multiparæ than among primiparæ. Previous pregnancy, therefore, imposes penalty, and implies added risk, and this risk almost invariably arises from local lesion, the imprint of incompetent obstetric practice or neglect. The importance of asepsis during, and repair, replacement and healing under correct postural rest, after confinement, cannot be overstated, nor too often repeated. It is amazing, in consulting gynæcological practice how numerous are the patients, who ascribe all their ills and the beginning of their continued suffering to their first confinement. The family physician may not be, in the slightest degree, responsible for the accidents of obstetric practice, but duty demands that they shall not continue as a penalty for his patient and a reflection upon his skill and care.

Lacerations should be repaired, normal positions restored and involution induced.

Causes of Abortion.

Uterine displacements, especially retroflexion, retroversion and descensus are most important causative factors. Persistent incarceration of the uterus in abnormal position renders continuance of pregnancy impossible, and abortion inevitable. Circulatory disturbances become initiated and established by the deformity. Uterine instability, therefore, arises from pathological lesions incidental to displacement. Normal decidual development premises normal histological structure and physiological function. An unhealthy endometrium, therefore, becomes responsible for decidual abnormalities and diseases. These decidual defects constitute, in the majority of cases, the direct specific cause of abortion, and suggest the only truly rational procedure for its prevention. "Habit of abortion" is a loose, misleading term, deserving deletion from our literature and teaching. Definite cause and inevitable effect form the only sound bases for investigation.

Constitutional causes, such as tubercle and syphilis, may exercise baneful influence, especially if superadded local lesion exist in the genitalia. Further, circulatory disturbance and resultant decidual instability may arise from cardiac, pulmonary, renal or hepatic disease. Nor must it be forgotten that increased intra-abdominal pressure from tumour or other cause may similarly interfere with decidual nutrition, and thus predispose the patient towards abortion.

Deep cervical laceration, another index of negligent obstetric practice, is frequently a potent accompanying factor, or, more correctly, one of a number of associated lesions tending in the same direction. These lesions, intrinsic and extrinsic, must be grouped, since they are inter-dependent, and arise from the same causes.

Prophylaxis and Treatment.

Pregnancy and its continuance are natural physiological processes, directly dependent upon normal anatomical relationships, freedom and function.

Aim earnestly, therefore, at the earliest possible period, to re-establish relative anatomical relationships and freedom, and thus, on the only rational basis, replace aberrant function by physiological process. If abortion has occurred, thus guard against recurrence.

During existing pregnancy, if abortion has previously occurred, guard the patient against undue effort, against worry and allied mental disturbance and fear, and, above all, against physical or mental shock. Exercise, in each individual case, well-balanced judgement, and avoid hasty, ill-warranted conclusions, since they bespeak inexperience and ignorance. Guard against obsessment arising from previous occurrence of abortion, and do not regard abortion inevitable until it is really so. Rupture of the membranes and escape of aminotic fluid indicate inevitable abortion. In all other cases and under all other conditions hope, however feeble, is warranted, that the pregnancy may continue to term. Judgement will assign the cases suitable for aid, and will exclude those already beyond the realms of successful treatment for saving the fœtus.

Avoid, whenever possible, the use of drugs, or rather use them as aids than as direct reliants. They are often poor substitutes for more rational procedure. Though wondrous aids when judiciously administered, their use on a pregnant woman without synchronous correction of uterine deformity, displacement or fixation marks a low standard of obstetric knowledge, which will surely react upon the practitioner. Yet special skill is unnecessary unless operation be demanded. Cultivate the habit of patient methodical examination. Accurate, reliable information, however skilful the clinician, can alone thus be obtained, and upon the facts thus collected can sound judgement alone be based.

Note, since great clinical importance therein rests, the precise period at which, in previous pregnancies, spontaneous expulsion of the ovum occurred. Usually, during the first half-period of pregnancy the ovum is expelled *in toto*, whilst during the second period the course of events is similar to that observed at full-term labour. It is rare, in cases of criminal abortion, to find total expulsion of the ovum.

Differentiate, beyond doubt, inevitable abortion from that which is threatened or even imminent.

Attempt to save a fœtus after rupture of the membranes and escape of *liquor amnii* would be foolish.

Inevitable abortion demands immediate completion upon aseptic conservative lines. Duty, however, does not end here. The causes, constitutional and local, require scrupulous investigation and remedy, so that, during the next pregnancy similar conditions and causes may not prevail and exercise their damaging and dangerous effects.

In a busy practice existence of hitherto unrecognized or unheeded causes will, with surprising recurrence, be proved, and every effort thus made will be repaid by resultant satisfaction and success.

Further, the results, which will surely accrue from surgical correction of laceration, deformity and fixation in accordance with accepted principals of gynæcological practice will, themselves, add strong conviction.

I desire particularly to place before colleagues what I believe to be the best treatment for threatened or even imminent abortion due to retro-displacements, without or with, accompanying fixation of the uterus.

Abortion is threatened when, during the earlier weeks of pregnancy, the patient begins to lose blood from the uterus, and suffers accompanying pain in the back and lower abdomen, the pains periodically extending downwards and forwards towards the uterus.

Such threatened abortion does not become imminent until the hæmorrhage is profuse, and the *cervix uteri* becomes considerably dilated. Imminent abor tion, therefore, premises profuse hæmorrhage, even though insufficient to endanger life, accompanied by cramp-like pains due to uterine contractions which, later, however, become distinctly bearing-down in character. Such conditions, it must be granted, advance the danger so close to the border line of inevitable abortion that judgement in each individual case will alone find warrant, or otherwise, for attempted saving of the fœtus. The saving of two lives presents in consideration of every case.

Safety against error from bleeding or pain due to other causes rests upon precise, careful examination. Until inevitable abortion is proven, warrant persists for saving the fœtus, unless the mother's condition contra-indicate such attempt.

Formerly I believed that dual occurrence of hæmorrhage and pain rendered abortion inevitable irrespective of causes, but increased experience has broadened my outlook and strengthened my hope and confidence in all those cases where uterine displacement is responsible for the threatened catastrophe. Surgical correction, which, after all, is the only rational procedure, if early applied, will assuredly prevent abortion, and there really exists no valid reason against such correction being made during pregnancy, apart from the saving of the fœtus. Risks will be scarcely increased, and the advantages tendered by involution under improved conditions, after delivery, are surely great.

I am conscious that such views will be contested. will be ascribed to ultra-surgical intent, will even by some be condemned.

But under calm judgement and without bias, let this extremely important subject, in its widest aspect, be reviewed.

Presumably the patient is pregnant, and suffering from threatened or even imminent abortion, resulting from posterior displacement, without or with fixation of the uterus.

Presumably, further, the pregnancy is still at a comparatively early stage, since, normally, during the third month the uterus begins to rise above the symphysis, and to establish normal anteflexion.

Deterrence of these normal processes of elevation and physiological anteflexion will prevent adaptation of the uterus to its increasing contents, and nor mal intermittent contractions will assuredly be replaced by painful ones, resulting, 'ere long, in spontaneous expulsion of the ovum.

When fixation exists, abortion is inevitable unless it be relieved. Relief from fixation alone offers hope, and this relief demands abdominal section. Rest and drugs may be, and surely are, valuable accessories, but they offer no greater aid than they do in in carcerated hernia. In any such case they are not substitutes for such rational procedure as removal of the cause. Unless, therefore, some condition of the mother contra-indicate, I hold it a rational, safe procedure to open the abdomen, free the uterus and suspend it by its ligaments in corrected position. The operation, backed by experience, is both easy and safe, and in a limited experience, it must be granted, exceptionally satisfactory. I shall be glad to learn any alternative for such rational and sue cessful procedure.

Next stand cases where the pregnant uterus threatens to abort on account of uncorrected retroflexion, or retroversion of the uterus without organic fixation of the organ in the pelvis.

I will grant that in the absence of fixation the prospects for continuance of pregnancy are reasonably good under proper treatment. Here, again, rest and drugs prove valuable accessories, but they are not substitutes for more rational, hence more correct, procedure.

Except when, as occasionally happens, spontaneous rising and anteflexion of the uterus occurs, continuance of pregnancy is doomed, unless the organ be elevated and kept in position by some artificial means. In order to place "pessary relief" and surgical relief in correct perspective for comparison, it is necessary to consider briefly the use of a pessary under the above condition of threatened abortion.

An incarcerated uterus is not necessarily a fixed uterus, since increased size alone may prevent its escape from the promontory of the sacrum. The rectum and bladder being emptied, anæsthesia administered, the patient placed in the knee-chest posture, the cervix being gently, yet firmly, pulled down towards the outlet, whilst two fingers introduced into the rectum are pushed against the fundus. All discomfort may be relieved, and the uterus be placed in normal position for bearing its contents to term. Thus, alone, can spontaneous expulsion of the ovum, previously inevitable, be avoided. The feat is often difficult, and involves much greater

manipulation and exercise of pressure upon the pregnant uterus than is necessary through an abdominal incision. Moreover, considerable additional risk is involved, if inflammation be present in any collateral structures.

I believe the judicious use of a pessary a sound alternative for spontaneous expulsion of the ovum, loss of a potential life, and one warranted by men inexperienced in pelvic and abdominal surgery. But I hold, with strong conviction, that the best treatment is surgical procedure, carefully planned, for relief and correction.

It may be interesting to know upon what evidence such strong conviction is based.

In four cases of fibro-myomata of the uterus complicating pregnancy I have succeeded in enucleating the tumours without disturbance of pregnancy. Three of these cases have been reported. Such complete success convinced me of the tolerance of the pregnant uterus provided direct contact with the organ itself were avoided. A vulsellum attached to the tumour is the only support necessary, in addition to packing, during operation, until suture ends are substituted as supports for it.

The principles involved in Gilliam's method of uterine suspension are sound, but it has one defect. When the operation first came under my observation some years ago I failed to grasp either the necessity or wisdom of perforating the sheath of the rectus muscle, and therefore I have never done it. I have performed a modification of it in hundreds of cases with entire satisfaction. For suspension of the uterus, virginal or pregnant, I am convinced that it has no equal. It is extremely simple and easy, but demands care and correct sequence.

In some cases of sterility, where dilatation, curettage and suspension were performed, pregnancy early supervened, and delivery occurred within one year, the uterus thereafter remaining in corrected position.

I became convinced, therefore, that a retroverted pregnant uterus might be suspended with good prospects. I therefore sought for a pregnant patient the subject of previous abortions due to such condition, and who, based upon precedent, might again abort. Ere long, one presented. She was ten weeks pregnant, and had been suffering the dual signs of threatened abortion for some hours. The uterus, acutely retroflexed, was freely moveable, but could not, without a pessary, be kept in corrected position. I suspended the uterus, sedatives were freely administered so that no post-operative pain was suffered, and pregnancy continued to term, and ended in satisfactory delivery.

In another similar case I not only suspended the pregnant uterus, but released the organ from adhesions, which would have rendered abortion inevitable, and at the same time repaired a relaxed outlet with equally satisfactory result. In this case I did not deem it expedient to repair a lacerated cervix, which was also present. Under good obstetric practice this should have been long since repaired by her previous attendant.

These are the only cases in which the operation has been completely successful, but they are the only ones in which it has been fully tested.

I have recently operated upon two similar cases. In both the dual signs of threatened abortion, pain and hæmorrhage, were present, but the uterus was freely moveable in each. Both had aborted, one twice, the other three times, since their last delivery, so that, *a priori*, recurrent abortion might reasonably have been feared. Sedatives were freely administered to control pain, and all other known means of guarding against abortion had been observed. One suffered considerable nausea and vomiting before the operation, and was not desirous for continuance of pregnancy. As an additional guard, in this case, I inserted after operation a Hodge pessary. She still suffers from vomiting, and complains of pain in the left lower abdominal quadrant, but pregnancy continues. The uterus having now risen above the pelvis, I shall remove the pessary.

These cases, though few in number, by their success, are sufficient for establishment of basic principles. The risks of abdominal section, apart from anæsthesia, for such a simple operation in the hands of competent surgeons, is almost a negligible quantity. I am confident that if we cannot succeed by this method in checking abortions due to such conditions, the risk for the mothers will be less than the abortions themselves would incur. For the fœtus hopes are greatly increased. Inevitable death awaits the fœtus of an incarcerated uterus. Further, manipulation and pressure associated with the use of a pessary, though imperatively demanded, hence unavoidable, adds danger to both the mother and the fœtus.

Sentiment throws a heavy pall over operative procedure on a pregnant woman until, as when abortion is inevitable or has occurred, operation is demanded without delay. Familiarity though with curettage has rendered it less offensive and more acceptable to our patients.

I grant that the views herein expressed with so much confidence and, so far, warranted by experience inspiring it, open up a wide field, and for the rash and inexperienced, a dangerous field for exploit.

Yet abortions, and especially recurrent abortions, which might thus be avoided, are themselves a profound source of distress and danger to women, a danger which unfortunately is frequently not lessened but increased by vulgar obstetric practice. Suspension of the pregnant uterus demands experience in abdominal surgery, and should not, in its absence, be attempted. In competent hands it is easy and safe, and there is no valid reason why it should not be so. Asepsis is imperative.

The Operation.

I shall briefly describe the plan I myself follow. A median abdominal incision is made, the length of which will vary with the depth of the abdominal wall. In order that each layer may be accurately closed, especially at the ends, I make the incision a little shorter in each successive layer. Such a plan aids the ease and efficiency of closure, and this closure is of considerable importance, since the

newly healed tissues must bear the increasing pressure of advancing pregnancy.

The intestines and omentum are carefully packed, and the pregnant uterus exposed. The gloved hand is then gently swept over the posterior surface of the uterus, and any adhesions exposed are divided between forceps or ligatures. A strand of catgut (No. 2 chromic) is then passed on a round, curved needle, beneath each round ligament at a distance of about two inches from the uterine end. I say about two inches, since the exact position must be decided in each case. Each strand is held by forceps.

A small curved forceps is then passed outwards beneath the sheath of the rectus muscle. The centre of the body of the muscle is penetrated, and the instrument is pressed through into the abdominal cavity. The chromic catgut ligature is picked up, the forceps withdrawn, and the round ligament presents in the abdominal wound. Both ligaments are now drawn up, and the correction on the uterus observed. Pads are removed, the omentum brought down, and the peritoneum closed. Each ligament is then sutured to the sheath of the rectus of the opposite side. The abdominal incision is closed in layers. If the operation be carefully performed the uterus need not be touched throughout the operation.

SUDDDEN COLLAPSE DURING CHLOROFORM ANÆSTHESIA.

By **Norman Pern, M.R.C.S., L.R.C.P.,**
Port Fairy, Victoria.

Collapse, due to such rare causes as epileptiform seizure, apoplexy, etc., is not considered.

The conditions under which a patient with apparently normal heart and lungs, and suffering from no obstruction to respiration, may collapse suddenly under chloroform administration are:—

(1) *During the Early Stage*, that is, from the commencement of administration until the stage of surgical anæsthesia is reached:—
- (*a*) When commencing to inhale,
- (*b*) When the operation is begun under incomplete anæsthesia,
- (*c*) During the stage of excitement or struggling,
- (*d*) With sudden, complete spasm of the glottis and of all respiratory muscles, with or without struggling, and
- (*e*) Overdose, with insufficient air.

(2) *During the Stage of Surgical Anaesthesia.*
- (*a*) Sudden emptying of large cysts or empyemata, etc.
- (*b*) Sudden alteration of patient's position,
- (*c*) Overdose, and
- (*d*) Additional shock, due to the surgical operation, from handling of tissues or length of operation.

The cause of collapse under such circumstances may be due to either primary respiratory or primary cardiac failure, or possibly to both combined.

A.—Primary Cardiac Failure.

The following factors appear to be pre-eminent in bringing about primary cardiac failure:—

(1) Over-distension of the heart, particularly of the right side, during the struggling stage, from obstruction to the onflow of blood due to contraction of all the voluntary muscles, and from the restrained respiration.

The contraction of the voluntary muscles tends to force the blood in them on towards the veins and right heart.

At the same time, the calibre of the systemic arterioles, venules and capillaries in the muscles is considerably diminshed, owing to the contraction of the muscles on them.

Consequently, the blood pressure on both sides of the heart is greatly raised, and the general circulation obstructed by the contracted muscles.

The right heart is still further handicapped by the fact that respiration itself is practically in abeyance, or greatly restrained, owing to the spasm of the respiratory muscles, and, consequently, fails to aid the pulmonary circulation through the suction action of the blood, from the great veins normally exercised during respiration. Whether chloroform itself may have the effect of causing spasm of the cardiac muscle is open to question.

Chloroform causes contraction of all voluntary muscles, only during the early stage of administration. May it not as well sometimes cause cardiac spasm with the general muscular contraction? With careful administration and plenty of air, a struggling stage, when existing, always takes place after consciousness is lost, and under such circumstances cannot be due to a half conscious sense of suffocation or self-preservation.

(2) Reflex inhibition of heart due to:—
- (*a*) Psychical factors at the commencement of the administration, such as fright or fear of death;
- (*b*) Commencement of the operation before the patient is sufficiently anæsthetized;
- (*c*) Sudden alteration of patient's position;
- (*d*) Sudden emptying of large cysts or empyemata;
- (*e*) Shock due to handling of tissues during the operation or the length of the operation.

(3) The heart's action may be directly inhibited:—
- (*a*) By the direct effect of the chloroform on the cardiac centre in the medulla or on the cardiac nerves, *i.e.*, overdose, and possibly cardiac spasm during a struggling stage.
- (*b*) By alteration of blood pressure conditions brought about by the action of the chloroform on the vasomotor nerves.

B.—Primary Respiratory Failure.

Primary respiratory failure may be due to:—

(1) The effect of the chloroform on the respiratory centre in the medulla, and possibly also on the nerves which supply the lungs and the muscles of respiration, *i.e.*, overdose and possibly spasm of the glottis, and of all

respiratory muscles with or without a struggling stage.

(2) Reflex inhibition in the same way that the heart may be effected.

In considering the treatment of a case of chloroform collapse, whether during the early stage of administration or during surgical anæsthesia, the main hope of success lies in:—

(1) Constant and undivided attention during the administration to the character of the breathing, to the colour of the face and lips, to the condition of the eye reflexes and the position of the eyeballs, to any sudden muscular relaxation during a struggling stage, to sweating and the condition of the pulse, in order, as far as possible, to forestall collapse.

(2) Being prepared to act, with an exact and methodical programme in mind immediately the collapse occurs.

It seems immaterial so far as treatment is concerned whether collapse is due to primary cardiac failure or to primary respiratory failure, since the treatment should embrace the stimulation of both the respiratory and circulatory systems, there being little time to consider which occurred first, and only seconds to save the patient's life.

The routine treatment I have followed in these cases is as follows:—

(*a*) Lower the head;

(*b*) Gag the mouth;

(*c*) Draw out tongue with fine-toothed forceps, and leave them hanging or give to assistant to hold. The air passages are then free.

(*d*) The next act is to stand up and seize the patient's wrists, extending the arms fully backwards in a bold, sweeping movement. Give them to an assistant to hold in this position all the time artificial respiration is being performed. With the arms in this position, air rushes into the lungs.

(*e*) Step to the patient's left side and grasp the lower thorax, at the same time pressing with the weight of the body, according to the build of the patient, in order not only to drive the air out of the lungs but also as far as possible to compress the heart directly, with the object of squeezing out its contents and of stimulating it to contract. When the compression of the thorax is relaxed, air again rushes into the lungs, as long as the arms are kept fully extended. Artificial respiration is continued in this manner until the patient revives.

(*f*) A hypodermic injection of strychnine is given at once, say $^1/_{10}$ gr. or min. x. of *liquor strychninae* for an adult, and an amyl nitrite capsule is broken for inhalation.

(*g*) If this process of artificial respiration does not stimulate the heart to beat within a reasonable time, the only practical resource left I know of is to open the abdomen and to practise manual palpation of heart, aided by artificial respiration by Silvester's method. When the respiration alone is at fault, artificial respiration, of course, must be continued as long as is necessary.

(*h*) Should there be spasm of the glottis and of the respiratory muscles in the first instance, before air can be made to enter or leave the lungs, it will be necessary to perform laryngotomy or tracheotomy rapidly, and then to continue artificial respiration, as described above. The whole of the treatment can be carried out in a matter of seconds.

The following points should be kept in mind when chloroform is administered with an ordinary mask and dropper:—

(1) Have a convenient table at right-hand side, on which are placed all necessary anæsthetic requirements, such as gag, tongue forceps, hypodermic syringe charged, amyl nitrite capsules, bowl for vomiting, towel, etc., and ascertain that there is no denture in the mouth, and that the stomach is empty.

(2) Morphine should not be given beforehand, for fear of respiratory collapse, save in exceptional circumstances.

(3) Never hurry the patient under, and give plenty of air during a struggling stage.

(4) Throughout anæsthesia, when possible, the patient's head should be kept level with the body; the head should be turned well to the right side, the right cheek resting against a folded towel. The mask is held by the thumb, fore, and middle fingers of the left hand, the ring and little fingers of the same hand gently supporting the chin. One thickness of a soft towel should be interposed between the chin and fingers. This support allows of easy breathing, and the right facial pulse can be frequently felt by the middle finger of the right hand. The amount of chloroform the patient receives is largely regulated by the distance at which the mask is held from the face.

(5) Give the maximum amount of air with the minimum amount of the anæsthetic that will keep the patient sufficiently anæsthetized for the purposes of the surgeon.

(6) Pay constant and undivided attention to the nature of the breathing, the colour of the face and lips, and the state of the conjunctival and light reflexes.

(7) Always think of the heart and respiration.

(8) Discontinue the anæsthetic for a short time if in doubt of patient's condition.

(9) Apply face and lip friction with a dry towel and lower the head should the breathing become shallow.

(10) Prompt action, with a definite system to work on, must be taken should signs of danger develope.

The above remarks are made from the limited experience of some three thousand general anæsthetics without a fatality.

For minor operations in general practice, a mixture of equal parts of chloroform and ether on the

ordinary chloroform mask is a safe and ideal anæsthetic, especially for infants and children, the stimulating effect of the ether counteracting the depressing effect of it and the chloroform diluting.

Criticism will be welcomed.

Reviews.

YELLOW FEVER.

The series of publications issued by the Quarantine Service has now reached its sixth volume, and the standard of excellence established in the early numbers is certainly being maintained, if not enhanced. The latest volume deals with yellow fever from an Australian aspect,[1] and consists of an account of the epidemiology of this disease and a discussion of the danger of its introduction into Australia by Dr. Cumpston, a description of the clinical diagnosis by Dr. A. Breinl, and a record of the known distribution of the *Stegomyia fasciata*, in two chapters, by Mr. F. H. Taylor.

The Director of Quarantine makes good his case that a real danger exists of the introduction of yellow fever from the endemic foci on the Pacific coast of America, and possibly from more distant places, into Brisbane or other ports on the north-east coast of Australia. In the first place he examines the map of the world and the records to determine the past and present prevalence of yellow fever. The countries on the Pacific coast of Central and South America are dealt with, then he turns to those countries situated on the Gulf of Mexico, the Caribbean Sea and on the Atlantic coast of America, and, lastly, he speaks of the east and west coasts of Africa. The fact of yellow fever occurring in some of the countries indicated need not detain us here, since this is well established. Of greater interest is the history of the eradication of the disease from the Panama Canal zone and the simultaneous partial disappearance of the stegomyia. Quoting Major James, he shows that the continued freedom of this zone depends on the maintenance of the present arrangements. Stringent quarantine regulations exist. He urges that a trained intelligence officer should be stationed at Panama, to act as an outpost for Australia and Asia. In addition, he advocates an officer appointed by the Commonwealth Government in combination with the Government of New Zealand to guard ports of call, such as Samoa or Tahiti, should ships from America make these ports in the future. It is clearly shown that while the Panama Canal zone has been cleared of the tiger mosquito to a great extent, and that yellow fever is no longer endemic there, prophylaxis has been less thorough in other countries, and dangerous endemic centres act as a menace at the present time. Dr. Cumpston finds that opinions have been expressed in various quarters in regard to alleged safeguards in the short time during which the mosquito can become infected and in the fact that the infected mosquito cannot pass on the infection until the expiration of twelve days. He estimates the length of the danger period at anything up to 78 days after the commencement of a journey. Assuming that a person be bitten on shore, and that uninfected stegomyia are on board, the illness may become manifest when six days out; the mosquitoes may be infected three days later, and the mosquito may remain infective for a further 57 days. A careful analysis of the regulations or absence of them in many places where yellow fever is endemic proves that this disease could easily be carried to our ports. Mosquitoes are elusive, and the introduction of some specimens infected with the unknown virus could start a most disastrous epidemic in parts of Australia where the *Stegomyia fasciata* population is large. The means of protecting a country against the introduction of this infection are twofold. Either administrative measures must be rigidly enforced in those places where the disease is known to exist, and precautions must be taken at ports of call, or the *Stegomyia* mosquito must be eradicated, so that the introduction of a few infected individuals cannot lead to an outbreak.

The account of the epidemiological aspects of the subject and the examination of the question: Is the disease entirely under control in the countries where it exists? are handled skilfully, and form important and readable contributions to the yellow fever literature.

While the early diagnosis of yellow fever may be difficult or impossible, it is of paramount importance that a scientific diagnosis should be made as early as possible in every case in the interest of the community. The chapter on this subject is wholly excellent, and may be relied on as a guide to the attainment of this end. Lastly, the value of knowledge in regard to the distribution within the Commonwealth of the *Stegomyia fasciata* is essential if prophylactic measures are to be relied on. Mr. Taylor has undertaken a survey, the results of which must form the basis of a rational anti-yellow fever campaign. In addition to his own investigations and observations, he records the observations of others, and apparently goes near toward establishing a mosquito map for the whole of Australia. Sentinels and mosquito destruction, or rather inhibition, are the two pass words on which the safety of the Commonwealth in this respect lies. Dr. Cumpston has shown the way.

[1] Australia and Yellow Fever; Commonwealth of Australia, Quarantine Service; Service Publication, No. 6. By J. H. L. Cumpston, M.D., D.P.H., Director of Quarantine; A. Breinl, M.D., Director of the Australian Institute of Tropical Medicine; and F. H. Taylor, Entomologist to the Australian Institute of Tropical Medicine; 1915. Melbourne: Albert J. Mullet, Government Printer; Royal 8vo., 99. 95, with maps. (Issued under the authority of the Minister for Trade and Customs,)

Notes on Books.

DRINK AND THE WAR.

Professor D. A. Welsh contributed "something on the war" to *Hermes*, the magazine of the University of Sydney. He called the article "The Great Opportunity,"[1] and has now issued it in pamphlet form, the first impression having appeared in November, 1915, and the second in December. Professor Welsh has dressed an old story in new garments. He deals with national responsibility, liberty of the individual, and alcohol, and delivers a powerful lesson in favour of restrictions to be applied to our fighting men. In the existing circumstances prohibition of the sale of alcohol in the form of beverages would be counsel of perfection, but alas! an impracticable one. Professor Welsh advocates the next best substitute. His second theme is conscription, and he pleads well in its favour.

[1] The Great Opportunity, First and Second Impressions by D. A. Welsh, M.A., B.Sc., M.D., F.R.C.P. (Edin.), Professor of Pathology in the University of Sydney, 1915. Sydney: The Sydney and Melbourne Publishing Company; pp. 30 and 31 respectively; Crown quarto.

Naval and Military.

In the 138th list of casualties, etc., issued on February 3, 1916, the name of Captain A. L. Buchanan is included in the list of those ill at the First Australian General Hospital at Heliopolis. In the same list it is reported that Captain E. R. Cordner is seriously ill in hospital.

From the 139th list we learn that Captain H. M. Stephen, Captain R. W. Cunningham, and Captain W. Evans are ill in hospital at Heliopolis. Under those reported in hospital is Lieutenant-Colonel J. B. St. V. Welch.

Personal.

We have been informed that Dr. I. Silverman is leaving Walla Walla, New South Wales, and proposes to settle in Melbourne. His friends will recognize the necessity of the change of his name from Silbermann, in view of the fact that he is not a German.

Dr. E. H. Molesworth and Dr. E. H. Bottrell have entered into partnership. The practice will be carried on at Beanbah Chambers, 235 Macquarie Street, Sydney. Dr. Bottrell has just returned from Europe, and has now resumed practice.

The Medical Journal of Australia.

SATURDAY, FEBRUARY 12, 1916.

Misrepresentation.

Education authorities have had the problem of the health of the school child before them for many years, and by a gradual process the system of medical inspection and of provision for treatment has evolved. The British Medical Association has always insisted on the separation of inspection and provision for treatment, and has always claimed that the duty of the State is to use means for the discovery of physical defects and mental disabilities, and to make such arrangements with existing organization as would enable treatment to be applied. In certain cases, the profession has come to the conclusion that new organizations should be created for the purpose of treating these children, but even in these instances, opposition has been raised to the establishment of a departmental service. In Australia, the problem is actually less complicated than in Great Britain, and the present situation in New South Wales has arisen because the Education Department has not recognized the limit of its responsibility. The public is forced to send all children to schools. The State is therefore morally responsible for two things. In the first place, no healthy child should be exposed to contamination from other children, and in the second, physical disabilities, which may lessen the beneficial effect of education or render it entirely nugatory, should be sought for and, if discovered, those who have the responsibility for the health of the child should be warned of the necessity of having treatment applied. In other words, the State should organize and provide efficient medical inspection of the children, and adequate care of the school buildings; and in every cases in which a defect, which has not been detected before, and which may interfere with the progress of the child while at school, is discovered, the parents should be urged once, twice or many times to have proper treatment applied. The State has no right to apply the treatment on its own authority. Events of the past month have shown that the education authority in New South Wales is transforming a sociological problem into a political one. Inspection was introduced, and we may assume that care was exercised in the selection of the school doctors to undertake this work. Unfortunately, the twelve officers were required to do too much work within a given time, and it would seem as if their main endeavour was to discover trivial as well as obvious defects. Instead of following the lead of the old country, where following-up was applied extensively, the Department in New South Wales set to work to march past the mass of practitioners and to provide treatment by whole-time or part-time civil servants. The first attempt to provide this treatment was through the agency of a travelling hospital and a travelling ophthalmic clinic. The Chief Medical Officer claims in his report that these travelling institutions have been organized for out-back districts. His own map shows that they have been utilized in districts where doctors were available. Having broken faith with the medical profession once, the next move on the part of the Department has been to throw on the table a second card—but not the whole hand. This card was the appointment of a few medical practitioners to treat school children and possibly teachers. When the whole hand is seen, it will be found that the Department plans handing over the medical treatment of all the children in the State, and of as many adults as can be smuggled in, into a State Medical Service. The New South Wales Branch of the British Medical Association, being composed of men with eyes, ears and understanding, has seen through the thin veil, and has been able to picture the result of this scheme. A protest has therefore been raised, and the Minister has misinterpreted this protest to the public as a confession of callousness, cruelty and greed. A portion of the public press, ever on the look-out for sensation, has followed the lead of the Minister, and has attempted to blacken the profession in the eyes of the public. The forcible and excellent speech delivered by Dr. F. Antill Pockley, which we reproduce *in extenso* in another column, informs the public of the reasons, which have actuated the profession to refuse to be a party to this scheme of the Education Department. Medical practitioners are concerned in one thing before all others, namely, that all assistance

given to the community shall be efficient. There is no doubt that by the interference of the Department between the medical profession and the community, the assistance which would be rendered, would be inefficient and at times even harmful. The Department has it in its power to make arrangements with private practitioners of great experience, with hospitals, on the staff of which the most skilled specialists give their services without remuneration, and with Lodge doctors, who are selected by the citizens of the State as their trusted medical attendants. These are the agencies which can supply efficient treatment for school children. Contrast them with salaried practitioners appointed to positions which are little tempting and only moderately remunerated. The community would soon discover the difference, and would demand that the children be placed in the care of men of their own choice, men on whose judgement and experience they can place full reliance. In spite of the fact that the medical profession is acting in the best interests of the children, some newspapers, led by the Minister, accuse it of inhumanity. No threats of removal of names from the Medical Register will deter the profession fro n resisting a scheme, which is calculated to harm children, parents and doctors.

AUSTRALIANS AND FEDERAL INSTITUTIONS.

Our attention has been drawn to an anomalous position existing at the Australian Institute of Tropical Medicine. It is now more than four years since the Federal Government selected an Austrian subject, of considerable repute as a scientific worker, to be Director of the new Institute at Townsville. The selection was made deliberately, and everyone, who has studied the excellent manner in which Dr. Anton Breinl has conducted the Institute, and who has measured the valuable assistance which he has given to our soldiers returning from New Britain infected with malaria, will recognize that the appointment has been a scientific success. Dr. Anton Breinl became a naturalized British subject some months before the outbreak of war. No one, as far as we are aware, has impugned his loyalty to his adopted country, and we understand that he has given evidence of it to those responsible for his continuation in office. This question, however, raises a matter of principle. We hold that the Federal Government should search the Commonwealth through and through for the purpose of finding suitable officers for its institutions. Should it be found that no suitable men are available, or those who are fitted for the position are not willing to serve, candidates should be sought in other parts of the Empire, but not outside it. It is conceivable that a special type of medical man may not be procurable for a given purpose out of a medical population of under 3000. But when the choice is extended to a community of something approaching 40,000, it is unlikely in the extreme that a first-class practitioner could not be found for any Federal or State appointment of importance. In the case of Dr. Breinl, it must be recognized that he had held important positions under British rule before he took up his present duties. The Directorate of the Institute and the Federal Government are competent of judging whether the present arrangement should be disturbed or not. We hope, however, that in all future appointments, persons of alien origin will be excluded, and that the choice will be limited to those of British Imperial birth and origin. Australians must come first.

MECHANICAL APPLIANCES FOR DISABLED SOLDIERS.

We understand that some, if not all the State War Councils and the State War Medical Committees find that their utility is likely to be limited by the partial failure of the Government to place sufficient means at their disposal to carry out their obligations to the returned wounded soldiers. It is early as yet to form a reliable opinion as to the prospects of success of these bodies in putting these unfortunate men in the position to earn a sufficient living. It is an expensive matter to teach adults a new trade, and it appears to be doubtful whether the public will be willing or able to supply the money required, if the Commonwealth Government does not recognize its responsibilities. Apart from the teaching of trades, there is the provision of mechanical appliances for the maimed. The Defence Department has apparently referred the State War Councils to the voluntary agencies, such as the Red Cross Society, for assistance in providing artificial limbs and similar mechanical appliances. The Red Cross Society is willing to grant the necessary money for this purpose, but it is widely held that the Government should not attempt to get rid of this responsibility. The men have been wounded in the service of the Empire, and will feel the disabling results for the rest of their lives. Even when suitable occupations are found for them, when they have been equipped for their new callings, and provided with missing

limbs or apparatus to cover the anatomical and physiological defects of their maiming, they cannot be as they were before, either in their ability to meet the struggle for existence or in their full enjoyment of work and leisure. Surely the Government should regard the provision of mechanical aids as a small compensation for the self-sacrificing devotion shown to duty. The work of the bodies established to render assistance to these men is still young. We are convinced that the Government will be inclined to listen to the claims of these citizens and to do what is just.

PARATYPHOID FEVER.

The occurrence of fevers due to organisms known as the paratyphosus bacilli at the front, and the fact that these affections are clinically extremely like enteric fever, have directed attention to the diagnosis, clinical characters and pathology of these diseases. The history of paratyphoid fever is a short one. After Widal had described his agglutination reaction for enteric fever in 1896, it was found that at times the serum of a patient suspected of enteric fever agglutinated organisms with characters differing from those of the *bacilli typhosus*. In 1901 and 1902, Brion and Kayser, and Schottmüller described two bacilli, which were afterwards known as *bacilli paratyphosus A* and *bacilli paratyphosus B* respectively. For a considerable time the latter was regarded by many authorities as a cause of food poisoning, and was classified with Gärtner's *bacillus enteritidis*. The similarity of the paratyphoid and the typhoid bacilli was marked, but the behaviour in the biological tests enabled the bacteriologists to distinguish them without difficulty. Castellani devised a means of determining when a mixed infection was present, or when the agglutination of both paratyphoid bacilli and typhoid bacilli was due to the so-called partial agglutinins. Having ascertained the agglutination titre to each, Castellani added a fresh supply of the bacillus yielding the stronger reaction again and again until the added bacilli had absorbed all the agglutinin active to itself. The tests were carried out with the centrifuged serum dilution. If the serum deprived of its typhoid agglutinin still agglutinated *bacillus paratyphosus*, the case from which it was derived was to be regarded as a mixed infection. Recent workers have shown that paratyphoid is comparatively common, and have proved that both the A and B bacilli produce illness similar to enteric fever. Captain J. A. Torrens and Lieutenant R. H. Whittington, R.A.M.C., have recently published a note[1] descriptive of the clinical features and diagnosis of paratyphoid fever. Their attempt to guide others to distinguish paratyphoid fever from enteric fever clinically is unlikely to be successful, but their experience as well as that of their colleagues in the various theatres of war will incite clinicians to suspect paratyphoid more frequently in the future than in the past, and to appeal to the bacteriological laboratory for a definite differentiation between the two diseases. The accumulation of knowledge and the extended clinical experience will doubtless cause a revision of the text-book description of paratyphoid fever to be undertaken.

[1] Journ. Royal Army Medical Corps, October, 1915.

Public Health.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending January 30, 1916:—

	Metropolitan.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	76	5	40	1	116	6
Scarlatina	23	1	19	0	42	1
Enteric Fever	17	1	52	2	69	3
Pulmonary Tuberculosis	31	11	31	18	62	29

The following is the number of epidemic cerebro-spinal meningitis cases reported to the Board during the week ending January 30, 1916:—

	Metropolitan Area. Cases.	Rural Districts. Cases.	Totals. Cases.
Military	—	—	—
Civil	2	—	2

SMALL-POX IN NEW SOUTH WALES.

The following cases of small-pox have been reported to the Department of Public Health, New South Wales, during the week ending February 6, 1916:—

	Cases.
Newcastle	1
Singleton (infected at Newcastle)	1
Total	2

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending January 29, 1916:—

Disease.	No. of Cases.
Diphtheria	43
Scarlet Fever	9
Enteric Fever	57
Pulmonary Tuberculosis	15
Varicella	7
Cerbro-Spinal Meningitis	4
Erysipelas	4
Total	139

INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the week ending January 22, 1916:—

	Enteric Fever. Cases.	Diphtheria. Case.	Phthisis. Cases.	Scarlet Fever. Cases.
Fremantle	—	1	—	—
Fremantle East	—	1	—	—
Fremantle North	—	1	—	—
Subiaco	—	1	—	—
Perth	1	1	2	—
Maylands	—	1	—	—
Midland Junction	1	—	—	—
Victoria Park	—	1	—	—
Kalgoorlie	1	—	—	—
Albany	—	—	—	1
Cannington	—	1	—	—
Armadale-Kelmscott	—	4	1	—
Greenbushes	2	—	—	—
Totals	5	12	3	1

Abstracts from Current Medical Literature.

DERMATOLOGY.

(50) Alopecia.

W. Knowsley Sibley (*Practitioner*, December, 1915) classifies alopecia as congenital, senile, and premature. The premature form occurs in two varieties, the idiopathic and the symptomatic. The constitutional causes include the acute specific fevers, tuberculosis, diabetes, syphilis, leprosy, neuroses, sudden shock, and prolonged anxiety. The local causes are chronic seborrhœa, inflammatory conditions in the scalp, *lupus erythematosus, morphœa, folliculitis decalvans, keratosis follicularis* of ichthyosis, ringworm and favus, syphilitic eruptions, local injuries, including X-ray and other burns, reflex nerve disturbances. The author points out that the life of human hair is limited, and that there is a continuous slow falling out, which is more marked in summer than winter months. The growth of hair is more active at birth, at puberty, and in old age, when strong hairs, known as vibrissæ, tend to appear. It is also active at times at the menopause, and in many cases a downy growth may take place during pregnancy. He estimates the average length of a hair of women in England at about 30 inches. When a pathological falling of the hair occurs, short hairs come out together with the long ones, and the proportion of short long hairs is an index to the amount of trouble present. Baldness may result from the wearing of hard and heavy hats, or of tight collars, from shallow breathing, from wetting the scalp too frequently, from indoor occupation, from derangement of the digestive or genital organs. The reasons why women are less frequently bald than men are that they pay more attention to their hair, and therefore detect commencing seborrhœa earlier than men; the connective tissue bundles of the scalp are larger in women than in men, and the cushion of fat is therefore better preserved; women are chest breathers; women wet their scalps less frequently than men; they do not wear tight-fitting hats of impermeable material. The diagnosis of alopecia should be made with exactness as to the cause before treatment is applied. For seborrhœa the scalp should be shampooed with soft soap and spirit in equal parts. Euresol, hydrocyanic acid, ichthyol, lead, lysol, mercurial preparations, quinine, resorcin, salicylic acid, sulphur, and tar are frequently used. Resorcin as a 2% solution will be found most efficacious. When tar preparations are required, *liquor carbonis detergens* or oil of cade are recommended. After the seborrhœa is cured ammonia, cantharides, carbolic acid, chrysarobin, formalin, or lysol may be used to excite the growth of hair. The author prefers lysol as a rule. He advises X-ray treatment in some cases, ionization, vaccines and massage in special cases.

(51) The Acne Bacillus and Staphylococcus.

S. H. C. Benians (*Brit. Journ. of Dermatology*, November, 1915) records some of his investigations, which were conducted with organisms obtained from the comedones of *acne vulgaris*, and included their action on (1) Keratin, for which purpose the shavings of bovine horn were used. It was found that the *staphylococcus albus*, growing in neutral broth, either alone or in association with *bacillus acnes*, caused the partial disintegration of the keratin. This disintegration was observed to be greater than that due merely to the alkalanity of the medium, produced by the organisms. The *bacillus acnes* was unable to produce a similar destruction. When olive oil was added, the keratin was not acted upon by the *staphylococcus albus*, or the *bacillus acnes*, and the medium then became either neutral or acid in reaction. (2) Fat, under a complete layer of oil, on broth the *staphylococcus albus* showed only a slight growth, due to the anaerobic conditions, and sometimes lost its pigment-forming properties. Partially covered with oil it grew freely, formed soapy matter, split off oleic acid, and formed gelatinous coagulable masses. Under similar conditions the acne bacillus grows freely, liberates fatty acids of a higher melting point in some cases than the original fat, or than the pure fatty acid of the same nature. It also in many instances produces a brown coloration, and this to a greater extent when associated with staphylococcus albus. (3) Fluid media: Nutrient bouillon being used the staphylococcus albus produced an alkaline reaction, without any foul smell, whilst the acne bacillus produced a very foul smell, which was found to be inhibited by the presence of fat in the medium when an acid reaction manifested itself.

(52) Lupus Erythematosus.

H. W. Barber gives the clinical history of a case of acute lupus erythematosus (*Brit. Journ. of Dermatology*, October, 1915). The patient was a female aged 43 years, who had had myxœdema at the age of 24, and was treated with thyroid for about eight years. Sixteen years ago she was exposed to sun and wind at the sea, and the skin of her face became irritable and sore. Two red scaly patches persisted on the cheeks. Three years later she was treated with Unna's salicylic paste, and the patches cleared up, faint scars remaining. Four years later a new patch developed on the right cheek. In 1913 it was cauterized. In April, 1914, fresh scaly areas appeared, on the left ear and also on the right side of the lip, cheeks, and ear. Her hair began to fall out about this time. Under X-ray treatment she became worse. Fresh patches developed on the chin, forehead and left elbow. The eruption was then a scaly erythema, with thickening and œdema of the skin, and typical telangiectatic scars. The urine contained indican, but no albumin or sugar. The temperature was normal, but later on rose to 99.4° F. The faeces contained a practically pure culture of *streptococcus longus*. Sour milk treatment was begun, and calamine lotion was applied locally. On July 19 the temperature rose to 103.6° and fell again during the following three days. On the 24th it rose to 104.2°, and the patient became extremely ill. The illness then subsided, and the rash became much less intense. Later it disappeared with amazing rapidity, and the skin was once again supple, smooth and only slightly stained. On the back, hands and elbows it became quite normal. On August 7 the streptococci were not found in the faeces, but had been replaced by coliform bacilli. The patient has continued to improve since. Barber suggests that the eruption was due to chronic absorption of toxin from an abnormal strain of streptococci in her intestines. During the apyrexial period the absorption of toxin was sufficient to produce the skin lesions, without giving rise to fever. The onset of fever heralded a septicæmia or great absorption of toxin into the circulation.

(53) Late Radium and X-ray Reactions.

Tinzi (*Journ. Roentgen Society*, July, 1915) reports five examples of late radiological reactions. The first two occurred in patients treated by X-rays In one the reaction appeared two years after treatment, in the second one year after. The first was a case of lymphadenoma, in a patient who had failed to respond to arsenic. Filtered rays only were used, and were not pushed beyond a mild erythema. The patient died four years after the commencement of the treatment. In the second case there was a sarcoma in the groin. The late manifestations occurred approximately a year later. The patient recovered completely. In each case the onset was sudden, and was accompanied by intense pain, and the appearance of a deep purplish-red hue, accompanied in the first case by vesication. In each case the appearance was exactly similar to erysipelas. In the first patient it went on to ulceration. He agrees with Spèden that the late reaction is due to an obliterative endarteritis, but maintains that this is merely a predisposing cause, and that there must be an exciting cause also. The other three patients were people treated by radium. The caustic effect was used as well as the selective action of this element on the pathological tissue. In each case an intractable ulceration appeared on the site of an apparently successfully treated new growth. As regards treatment of such a reaction, it is essential that the ulceration be cleaned and the pain relieved. He advocates foments of 1 in 200 carbolic acid, followed by an ointment of 3% scarlet red in paraffin,

when the ulceration is clean. Rest is essential. He advises that in any case where this treatment has to be carried as far as possible, the patient be warned to lead a careful life, and to avoid producing a breach of surface, and strain.

(54) Intestinal Stasis.

In discussing the Röntgenological aspect of intestinal stasis, Howard Ashbury (*Baltimore Hospital Bulletin*, April, 1915) deals with delay in the passage of the opaque meal. He holds that, though open to many fallacies, X-rays have been given the foremost place in the diagnosis of this condition. Intestinal stasis is divided into two main groups; the conditions due to mechanical obstruction, and those due to simple delay without obstruction. In the second the symptoms are caused to a great extent by true auto-intoxication. The common causes of the first group are visceroptosis, intestinal kinks, adhesions, dilatation, etc., of various parts of the alimentary tract. The conditions producing the second group are incompetent ileo-caecal valve, spasm of this valve, angulation at the splenic flexure, dilatation either congenital or acquired, of the colon and redundancy of the pelvic colon with atony and elongation. He supports Jordan's view of the most likely explanation. In regard to technique, he finds that fluoroscopy and radiography are both essential. He divides the cases of this condition into three groups, hypokinetic, due to lack of muscular tone, dyskinetic, with anti-peristalsis, and dyschesia delay in the evacuation of the rectum with enlargement of the rectal ampulla.

BIOLOGICAL CHEMISTRY.

(55) Glycolysis in Human Blood.

H. Maclean and H. B. Weir have studied the disappearance of sugar that takes place when blood stands at a suitable temperature (*Biochemical Journal*, September, 1915). This change has been ascribed to the formed elements in the blood, since it has been invariably noted that the fluid constituents play no part in the destruction of the glucose. All observers are agreed that the red cells possess, in a high degree, a glycolytic function, but there is much difference of opinion as to whether the leucocytes have a similar function. These investigators have used the method of Bang, which has given satisfaction in the hands of the workers in the Lister Institute, but they have controlled their results by using, in addition, the method of Gardner and Maclean. Their results show that both red and white cells of normal blood take part in glycolysis. The white cells are much more active than the red cells in destroying glucose. The activity of the white cell as compared with the red cell varies roughly from 200: 1 to 1,000: 1. In leuchæmic or other blood containing excess of leucocytes, glycolysis is much more active than in normal blood. In normal blood it is probable that the comparatively small number of leucocytes present exercise a somewhat greater influence on the total glycolysis than do the red cells, which are present in relatively large amount.

(56) The Diazo Reaction for Tyrosine and Histidine.

Ginsaburo Totani has devised a simple method of distinguishing between the diazo reaction of tyrosine and histidine (*Biochemical Journal*, September, 1915). This reaction, when observed in the urine was, at one time, regarded as specific for typhoid fever. Later it was noted that the substance that reacted with the reagents were tyrosine and histidine. Since it was well known that these bodies occurred in the urine in considerable number of conditions, the diazo reaction ceased to be regarded as a specific test for typhoid fever. It is easy to distinguish between tyrosine and histidine by means of the diazo test, by making use of the different colorations produced by reducing their similarly coloured diazo compounds with zinc dust and hydrochloric acid solution, subsequently rendering the solution alkaline with excess of ammonia. Tyrosine gives a rose-red and histidine a golden yellow coloration. The golden yellow coloration produced by histidine is specific for this amino-acid among the cleavage products of protein. The rose red colour of tyrosine is not specific for this amino-acid since the same colour can be produced by some other amino-acids, but taking into consideration the fact that the original reaction is only given by tyrosine and histidine it seems possible to detect the presence of tyrosine by the colour reactions. The reddish colours produced by tyrosine and other amino-acids in the secondary diazo reaction are readily destroyed by oxidation with hydrogen peroxide, resulting in the formation of a nearly colourless solution. The golden yellow colour of histidine is little altered, changing only to a lemon colour.

(57) Relation of Salivary to Gastric Digestion.

L. G. I. Maxwell has examined the effect of colloidal suspensions of starch in absorbing pepsin (*Biochemical Journal*, September, 1915). He finds that peptic digestion is delayed in the presence of colloidal suspensions of starch through absorption of the enzyme, the time interval being increased fourfold in the presence of a 2% starch solution. There is a stage in the disruption of starch at which the phenomenon of absorption of pepsin is lost. This occurs between the amylodextrin and erythro-dextrin stages. Unboiled starch does not hinder the action of pepsin, a factor of importance in the dietetics of herbivora. Cooked farinaceous foods, as rice, potato, bread, porridge and maizena, hinder peptic digestion if they are not subjected first to salivary digestion. Gum acacia causes marked inhibition of peptic activity. This is not prevented by previous contact with saliva. The saliva of man, in virtue of its ptyalin, plays a considerable part in aiding gastric digestion. It does this by hydrolyzing starch, which would otherwise absorb pepsin. It also is of importance in the production of dextrins which, as determined by Edkins, act as stimulants to the formation of the gastric hormone.

(58) The Preparation and Composition of Caseinogen.

J. Mellanby has prepared caseinogen from milk by precipitation with alcohol (*Biochemical Journal*, September, 1915). The protein forms a milk-white solution in water, possessing all the properties of caseinogen contained in milk. Comparative analyses of caseinogen and acidic caseinogen, prepared by precipitation with acetic acid, indicate that caseinogen is composed of a complex of protein and calcium phosphate. One gram-molecule of tri-calcium phosphate is contained in 3,500 gm. caseinogen. The amount of phosphorus in acidic caseinogen shows that one gram-atom of phosphorus is contained in 3,400 gm. acidic caseinogen. Six gram-molecules of acetic acid precipitate acidic caseinogen from about 3,500 gm. caseinogen. These relations suggest that the protein unit of acidic caseinogen has a weight of 3,500 gm., and that the molecule of caseinogen contains one unit of protein and one molecule of calium phosphate.

(59) The Composition of Commercial Lecithin.

H. Maclean has succeeded in carrying his researches on the nature of "lecithin" to a successful conclusion (*Biochemical Journal*, September, 1915). When phosphatides are extracted from tissues by means of alcohol they invariably contain large amounts of nitrogenous impurity. This impurity is very complex chemically, and contains bodies of a purin nature. The whole of the nitrogen of "lecithin" is accounted for by the cholin and the amino nitrogen present. "Lecithin" is a mixture in variable proportions of two somewhat similar bodies, one having its nitrogen present in the form of cholin, true lecithin, and the other containing no cholin, but having all its nitrogen in the form of amino ethyl alcohol, kephaline. By fractionation of the cadmium chloride salt of "lecithin" it can be separated into its two constituent portions.

(60) A Rapid Method for Determining Calcium in Urine and Fæces.

H. Lyman has made use of the turbidity principle in devising a quick method for the estimation of calcium (*Journ. of Biological Chemistry*, July, 1915). The three main steps in the process are (1) isolation of the calcium as calcium oxalate; (2) solution of the calcium oxalate in dilute acid; and (3) precipitation of the calcium as soap, and comparison of the cloud so formed with the cloud of a standard solution of calcium by the Duboscq colorimeter. The method gives sufficiently accurate results when compared with the figures obtained by the accurate process of McCrudden.

British Medical Association News.

MEDICO-POLITICAL.

An Extraordinary General Meeting was held for the purpose of considering and dealing with the whole principle of the Public Instruction Department providing treatment apart from inspection on February 4, 1916, at the B.M.A. Building, 30-34 Elizabeth Street, Sydney. The hall was crowded beyond its seating capacity. Dr. George Armstrong (the President) took the chair and called upon Dr. F. Antill Pockley to move three resolutions.

Dr. Antill Pockley, who was received with applause, said: "It has been delegated to me as Chairman of the Medico-Political Committee of the Council to take charge of the motions to be submitted to you this evening.

"It will be for you to say whether a report of our proceedings shall be given to the press, but inasmuch as the *Journal* is obtainable, and as the press and the public are taking a lively interest in the matter at issue, I shall have to speak at some length, and if I weary you by iterating facts and arguments well known to all of you, I must ask you to bear with me, so that the public may have a correct exposition of our attitude, and the reasons for the faith that is in us, if it be decided to publish them. With Dr. Worrall's ears and stop-watch on me, I shall try not to be discursive, and at the same time, bearing in mind that anything I may say may be republished from our *Journal*, will speak with a due sense of my responsibility, and it will be well for all the speakers to do the same.

"As most of you will perhaps remember, this is not the first occasion on which I have attempted to put before you the dangers, as they presented themselves to my mind, both to the community and to the profession of medicine, of ill-advised measures tending towards nationalization. In my Presidential Address to Congress in 1911 I referred to the subject at some length, and more than once in this room I have endeavoured to put before you the dangers, as they appeared to me, that were threatening the people and the profession, by certain moves on the part of the Government—moves that were all the more to be feared because of their insidiousness. It seemed fairly obvious that the Government would not make the tactical blunder of attempting to introduce nationalization at one sweep, but that they would adopt the insidious, nibbling process, and that is exactly what they are doing. On the occasions on which I spoke in these rooms, I failed to carry the meetings with me, partly, I believe, because of the vested interests that had already been created. I feel to-night, however, that I am on a good wicket, and that we are all at last alive to the dangers that are threatening the community and the profession." (Applause.)

"The motions which I have to propose have been very carefully drafted by the Medical Politics Committee. They are as follows:—

"(1) That the Association is opposed to State interference with the recognized system of medical practice and treatment, as being against the best interests of the community.

"(2) That any appointments of medical officers, prejudicial to the recognized system, will be declared inimical to the interests of the profession.

"(3) That the Association approves of the medical inspection, but not treatment, of school children by Government Departmental Officers.

"On the broad principles contained in the first part of the motion I can do no better than to quote to you my words to Congress:—

> "'We hear a great deal nowadays about nationalization of medical services. The matter is one of great moment, in which both the public and the doctors are concerned, and it is desirable that the motives and reasons determining our attitude should not be misunderstood.
>
> "'The tendency here, as elsewhere, is in the direction of State socialism, and in many matters the State is assuming functions and engaging in operations that have, in the past, been carried on efficiently and well by individual or corporate effort.
>
> "'If nationalization of medicine means that the State shall provide medical attention on all, rich and poor, by salaried State doctors, then we emphatically dissent, and we do so, not only in our own personal interests, but in the interests of medicine and of the public, and of the race.
>
> "'Medical men do not contend that their private and professional interests, should be upheld at the cost of those of the public, nor do they make any *ad misericordiam* appeal. The welfare of the community depends largely on the existence of a strong, competent, independent and sufficiently remunerated medical profession, and, without presumption, we claim that the value of our services in the past entitles our views to consideration in any scheme put forth. And yet we find that both in England and here on big social questions the views of the profession are ignored, their opinions not even asked, though we could materially help in their solution, and prevent the adoption of ill-advised schemes of well-meaning legislators and philanthropists. Indeed, on all social questions the advice of the doctor might be sought with advantage.'

"I might elaborate that a little by adding that it is essential for the welfare of the community that we should have a profession composed of men not only of ability but of character and integrity, and imbued with a spirit of loyalty to one another and to their profession. It is a fact that the public really accepts that a man, who does not play the game, but defies the opinion and custom of his profession, whatever the profession may be, generally for selfish personal ends, is untrustworthy and not to be depended upon in his relations with others.

"I said further to Congress:—

> "'The appointment of salaried State doctors would mean interference with freedom of choice of medical attendants, which is a privilege and an advantage that the public would be very unwise and probably very unwilling to part with. There is no disputing the fact that faith and confidence in his attendant is a very important aid to the patient's recovery. Want of confidence, and the feeling that his freedom of choice had been limited would, on the other hand, have a prejudicial effect.
>
> "'Moreover, the healthy and powerful stimulus of fraternal rivalry would be removed, or lessened, under a universal system of payment by salary, and the usual State plan of promotion by seniority. An all-round deterioration of the skill of the doctor and of the quality of the treatment would result. This would be to the detriment of the public and of progress in medicine.
>
> "'Further, the possibility, nay the probability, of a man having to depend for an appointment on his standing with this or that political or municipal party would tend to undermine that independence of thought and action so pre-eminently necessary in a doctor, not only when seeking an appointment but in his work. There would be the temptation to please the employer rather than the patient whenever the interests of the two happened to clash.
>
> "'The practice of the profession should be left free to follow its natural development, giving the best men the opportunity to advance the science and art of medicine, and to reap the honours and rewards, without which men of capacity and of the right class will seek other avenues for their abilities, and the profession will degenerate.'

"We fully recognize that in certain cases the interests of the community are best served by medical departments of the Public Service, as in connexion with His Majesty's Navy and Army, the administrative department of Public Health, isolation hospitals for infectious diseases, and hospitals for the insane. We approve of a proper system of inspection of State school children by departmental medical officers for the detection of physical defects and latent constitutional disabilities. We do, however, object to the perfunctory system of the 'march past', which led one of the inspectors, to her everlasting honour, to resign rather than to be a party to it, and which induced one of our daily papers, that has now taken the side of adversely criticizing us, to publish a cartoon depicting a row of pupils, with their tongues out, and the doctor rushing past them, stop-watch

in hand, saying '1, 2, 3, 4, 5, 6, 7, 8, 9, 10; beaten the record!' (Laughter.)

"We do object to the magnification of figures by the inclusion of trifling and negligible defects, which we know is done. There always exists the almost irresistible temptation to do such boosting up by departments specially created to look for and find such defects.

"We object to so-called statistics being published under official authority and warranty, and sent all over the world, professing to show that from 70% to 80% of our school children suffer from physical defects. It is an exaggeration and a libel on Australians." (Applause.)

"But while we would not object to a proper, efficient system of inspection, we do not approve of the treatment of the children by the same officers. Such a course of procedure for treatment is neither necessary nor desirable." (Applause.)

"It is not necessary because existing institutions, such as hospital and lodge doctors and private practitioners can do this work far better than the departmental officers, and without additional expense to the taxpayers.

"The existing systems for treatment of the poorer classes, as well as of those who can afford to pay, are sufficient and effective, and why disturb, by introducing a third party, a system that works so smoothly?

"Hospital doctors, lodge and private practitioners, being men of wider experience, and in the case of the two last, understanding the constitutional and other peculiarities of the patients, are better qualified to treat the children and do the important part of 'following up' than departmental officers are likely to be. These, if the Department should get them, will almost certainly be either junior men, or else practitioners, who, by taking such positions, would give proof that they had not been brilliant successes in their profession." (Applause.)

"Such a procedure for treatment is not desirable, firstly, because it would do away with the existing check on the diagnosis of the school inspector, and we have constant proof that such a check is necessary. Secondly, and more important, it is not desirable because it is a further extension of nationalization of the profession, which, as I have shown, is against the interests of the community. Not only would freedom of choice be taken from the patient and the sense of parental responsibility, already in this country feeble enough, be further impaired, but the profession would deteriorate if it were to become a department of salaried civil servants charged with the medical treatment of the community. And who can doubt that the system now attempted in connexion with State schools would be extended? We must all realize now the insidious methods by which nationalization is gradually being introduced. First we had the system of inspection, and a pause to see how we would take it. We looked askance at it, but did not object. Then we had the travelling hospital, avowedly for districts in which there was no doctor. Again we made no protest. We had no objection. But the map accompanying the last report of the Department, just issued, shows that inspection and treatment was carried out in Wagga Wagga, Henty, Tumbarumba, Corowa, Germanton and places within easy reach of Albury, Urana and Lockhart, though in the report itself it is stated that the Travelling Hospital 'works in those parts of the State where there are no resident doctors or dentist.' In plain English, the Department broke faith with us. They got our consent to the scheme under false pretences. Then came the travelling Ophthalmic Hospital, which undertook not only the examination but the prescribing of glasses for the children who needed them, and for many who did not, as well as for other ailments. Our suspicions began to be aroused, and we became restive, but made no organized protest. Here again the Department has broken faith with us, for they got our consent to this on their distinct promise that they would not treat eye cases where there was a doctor capable of doing it. They have not kept that promise. Now we have the attempt, not only to examine but to treat all school children in the metropolitan and other areas by the inspecting doctor, and here we cry 'Enough!'

"If we acquiesce, the next step will be the extension of the system to all schools, public and private. In fact, I see by the last report of the Department that the inspectors are now treating children in private as well as in State schools. The Government could not stop with State schools consistently with their pronouncement that there must be no class distinction of any sort, in their conception of a democratic country. Then we should have other State Departments, and eventually the whole community included. Our only hope of successful resistance is now, before the thing goes any further." (Cheers.) "I am informed, and quite believe, that at present only the boys with the best brains go to the Medical School, as the others feel that they would have little hope of passing the examinations, and the community gets the benefit of these brains afterwards.

"But what boys of talent or ambition will go in for medicine, if the most they have to look forward to is the position of a salaried civil servant, when there would be little or no incentive to excel, and they would be merely machines? Subserviency to political control, lowering of ideals, the inevitable Government stroke, a lack of ambition and of the stimulus of fraternal rivalry, that is provided for under our present system, would inevitably lead to stagnation and fatty degeneration of the soul. Our best men would seek more congenial avenues of employment, the general standard of the profession would be lowered, and the community would suffer." (Applause.)

"Of all the faculties, that of medicine has the longest, the most arduous and the most expensive curriculum. The average period of study is over seven and a half years, and this has to be followed in most cases by another year or two in hospital before the young practitioner is properly equipped to begin to earn a living.

"What sort of man would choose such a profession if the most he had to look forward to were the position of a civil servant with a salary of £600 a year, even if in a few cases it were raised after long years to perhaps £1,000—and, mark you, there is no reason to suppose, if the profession were collared (using the word in its literal sense) that these salaries would not be reduced to the level of say the public school teachers, who are scandalously underpaid?" (Hear, hear.) "That this loss of men to the profession would accrue under a system of nationalization is no vain imagining. It is significant that when it was foreseen that the National Insurance and Invalidity Act was coming in Great Britain, there was a marked falling off in the entrants to the medical schools, and still greater diminution when the Bill became law.

"And now for a few words in answer to the criticism that has been levelled at us by the Minister and a section of the public press. If we did not know Mr. Griffiths to be a shrewd man and an astute politician and by no means simple-minded, we might almost suspect that there was some influence behind him that had led him into a false position.

"We have been accused by the Minister of inhumanity and cruelty to the children, and a sordid grasping after fees, and the scandalous, though ridiculous insinuation has been made that we do not want the school children treated, because it would do away with their providing us with lots of work when they grow older." (Shame.) "I wonder what can have put such ideas into the Minister's head?

"The humanitarianism of the politician is frequently a pose for self-advertisement, the catching of votes or the gaining of political kudos. It costs him nothing. He sees to that. The humanitarianism of the doctor is of the practical, self-sacrificing kind, proved by the history and the practice of our profession from time immemorial, and our humanitarianism costs us hard work, loss of rest, loss of money, and even in some cases of our lives. And yet Mr. Griffiths dares to accuse us of cruelty and inhumanity because we seek to uphold the traditional glories of our profession, and to leave undisturbed the practice which has worked so well in the past.

"No self-respecting doctor ever refuses his help to a case of real suffering, regardless of all question of remuneration. No doctor ever patents or keeps to himself (though in many cases it would mean an immense fortune) any new discovery in medicine, any new drug or appliance or improved method of operating or treatment; but gives it freely to the world.

"The only exceptions that I can recall to this universal rule and custom in the history of our profession were the Chamberlains, and they, though hundreds of years have

elapsed since their day, are still held up to execration by us for keeping their secret of the midwifery forceps. And yet Mr. Griffiths calls us sordid and grasping after money! A great deal has been made of this, and without the smallest reason. He has seized upon the wording of our resolution of the other evening, to the effect that the proposed scheme would be inimical to the interests of the profession. It was put in that form because it is only on that ground that our regulations empower us to deal with recalcitrant members. The speeches made that previous evening showed that we had the interests of the community at heart, as well as those of the profession.

"If we did object to the Government depriving us of a portion of our livelihood, we should only be acting as every other class would do. We do enough for the poor, and for the Government, in hospitals, etc., for nothing, as it is. Why in the name of fair play should we be expected to welcome a scheme that would deprive us of a considerable part of our incomes merely that Mr. Griffiths might gain some political kudos, when we honestly believe that it would be against the best interests of the community?" (Cheers.)

"I am altruistic enough to believe that if we thought that nationalization were for the benefit of the community we would not oppose it." (Hear, hear.) "Our history and actions have shown that in the past we have not only not opposed but have been in the habit of introducing measures for the public benefit, quite uninfluenced by the fact that such action reduced our earnings. We would do the same now, only in this case it is against the public interests." (Applause.)

"Finally, if the Minister is sincere in his wish to improve the conditions and the health of the community, why does he not improve the accommodation, ventilation, lighting, cleaning and general sanitation of the schools? Because it would not give him the advertisement that his new scheme would. He says it is because he has not got the money. But he can find over £5,000 a year for the salaries of these new officers (to say nothing of the cost of administering a new department), a sum which, capitalized at 5%, would give him over £100,000 to spend on the schools.

"We hear on all sides that the accommodation in the public schools is insufficient, the provision of shelter sheds inadequate, the lighting and ventilation in many cases bad, and the sanitary conditions scandalous. Why not put these right, instead of straining at a gnat while swallowing a camel? I have in my hand the report of the Commission on Tuberculosis, published two and a half years ago, from which I read you a few extracts, dealing with the Redfern Superior Public School:—

> "'The whole building, inside and out, is in a dirty condition, and appears to have had no repair, painting, or whitewashing for many years, and with its present defects, and in its state of repair, your Committee is of opinion that it would be impossible for the cleaners to give it a reasonable appearance of decency. In answer to questions, the cleaner stated that the walls were dry-brushed twice a year.
>
> "'The water supply consists of five faucets in a row on the western side of the basement wall. There is no other water supply in the building, and no washing accommodation.
>
> "'The closet accommodation, situated in the yard, away from the building, consists of one closed closet for the teachers, and an antiquated trough-latrine, covered with a row of wooden seats, for the scholars. The woodwork does not appear to have been renewed since the closets were originally erected, and is dilapidated and decayed by age in many places. The flushing of this latrine could not be effected when visited, owing to the absence of the chain release, and in answer to questions, the caretaker stated that it had not been flushed since the last breaking-up. Owing to its construction, it is impossible for the scholars to flush it after use, and, in answer to direct questions, the caretaker stated that it was customary not to flush the latrine except in the evening after the scholars had left.
>
> "'The closet accommodation in the other departments of the school is similar. There is one closed closet for the teachers, and open trough latrines for the scholars.
>
> "'In the boys' school there is, in addition, a gutter urinal, which cannot be efficiently flushed.
>
> "'Girls' School.—This consists of two buildings, one of brick and one of wood. The statements made above as to the boys' department, apply in every particular to the brick building of the girls' department.
>
> "'There is, however, in the girls' building, an extra supply of water, with metal basins in the basement.
>
> "'The wood building is of one storey. It is much worse in respect of light and ventilation than the brick building. Directly under the window of this building, at the southern end, are the latrines of the girls' and infants' departments, and when these latrines are in use—the caretaker informed us, in answer to questions—this window has to be kept closed, owing to the effluvium from the ordure lying in the troughs of the latrines between the intervals of flushing.
>
> "'The building is dirty inside and out, and its state of repair is such as to make cleanliness impossible.
>
> "'Conclusion.—The whole place is so insanitary that, until repaired, and the more obvious defects remedied, its use as a school should be prohibited.
>
> "'The wood building of the girls' department should be immediately demolished, it being impossible to make it suitable as a makeshift.
>
> "'Whilst in the opinion of the Sub-Committee it is impossible to remodel the brick buildings in such a way as to render them satisfactory as permanent school buildings, they could be made to serve a temporary purpose if thoroughly repaired and cleansed, and the seating accommodation much reduced.
>
> "'The walls of such buildings as these should be sprayed at least once a week, and all necessary repairs promptly executed. These buildings could only be kept in fair sanitary condition by constant vigilance and at considerable expense. As will be seen by the statistical particulars, there would be serious overcrowding if the same number of scholars who have attended this school were seated in a suitable building of equal floor-space.
>
> "'The Sub-Committee thinks it would be highly desirable if a medical inspection and report were made as to the state of health of all teachers and scholars who have attended this school during the last two years.
>
> "'This school is a dangerous focus for the dissemination of tubercle, and your Sub-Committee is of opinion that any steps taken to combat tuberculosis where this, or any similar focus exists undealt with, would be useless.

"This report is signed by Dr. Paton (President), the late Sir Normand MacLaurin, Sir P. Sydney Jones, Sir A. MacCormick, Drs. Rennie, Hull, Nash, MacCulloch, Clubbe, Purser, Jamieson, Palmer, Griffiths, Flashman, Professor Douglas Stewart, Dr. S. T. D. Symons, and Dr. C. Savill Willis, though it is only fair to Dr. Willis to point out that, at that time, he was not in the Education Department.

"Mr. Griffiths has stated that the doctors' fees are higher than those of any other profession. Of course we know that they are not, but if they were we should deserve them, for our work is the most arduous, exacting, constant, and health-wracking of all the professions. Also, even in times of peace it is the most dangerous, while in time of war recent events have shown that the doctor is even more exposed to danger than the fighting man, as in proportion to numbers the casualties are higher in the medical corps than in the fighting line." (Applause.)

"Mr. Griffiths has threatened that if we will not meet in consultation members of whose actions we disapprove, he will introduce a Bill to compel us to meet them, under penalty of having our registration cancelled. He might remember the proverb about taking a horse to water and trying to make him drink. But what a surprising attitude for a trade unionist to take up! He should be reported to the Trades Hall. Mr. Griffiths says we are a trades union, and yet he would compel us to surrender the cardinal principle of unionism, that of being able to refuse to work with non-unionists. He could not logically object if we were to strike. By the way, one of the papers heads an article 'The Doctors' Strike,' because we refrain from applying for certain appointments. If we really went on strike, say in the hospitals, where would the Government be that had brought about this state of affairs? Of course, such a thing is unthinkable, because by so doing we should be hurting the community more than the Government, and this we

could not do, Mr. Griffiths and his accusation of inhumanity notwithstanding.

"Mr. Griffiths's published statement that the Departmental doctors treat school children in England without objection under the same conditions as he proposes is incorrect, disingenious and misleading. The conditions are absolutely different. He says that the doctors are doing without objection from the profession the work he is asking them to do here. It is not the case.

"In the first place, the schools in question there are the public elementary or board schools, attended by children of the very poor, not like our schools, to which go the children of all classes. Also, though the arrangements for treatment vary in different parts of the United Kingdom, they are all (according to the latest reports which I have been able to get access) on the lines for which we are contending. The treatment is carried out by outside practitioners, not by the inspecting doctors.

"Moreover, I have in my hand various reports of the Council of the British Medical Association at home, on this question, and I have to thank Dr. Todd for having put me on to them. At the Representative Meeting of the British Medical Association at Liverpool in 1912, at which I was present as your representative, it was resolved:—

> "'That the duties of School Medical Officers and their Assistants should be confined to necessary inspection and report, and that the treatment of those children found defective should not be undertaken by them.'

"Every year since this resolution has been re-affirmed, down to 1915, as quoted in a supplement to the *British Medical Journal* of May 8, 1915, when the above resolution was given as the *policy of the British Medical Association*.

"The Home Association also resolved that:—

> "'(*a*) Treatment by an education authority should be confined to necessitous children, that is, to those children whose parents cannot afford to pay privately for the treatment recommended as a result of inspection. Parents should always in the first place be recommended to seek treatment for their children from their family doctor.
>
> "'(*b*) The support of the Association should be given to the schemes by which medical treatment, and the treatment of refractions, should be carried out by local private practitioners. In areas in which such schemes are in operation the duties of the School Medical Officers and their assistants should consist of inspection and the important work of "following up."
>
> "'(*c*) Notwithstanding the suggestions in the attached Memorandum on Treatment at Voluntary Hospitals of School Children found defective on Inspection, it must be clearly understood that the policy of the Association is that the treatment of school children, found upon inspection to be defective, should normally be carried out by private practitioners and not through voluntary hospitals, but that in cases where the work is carried out through voluntary hospitals the policy laid down in the attached Memorandum on the treatment of school children at voluntary hospitals should be enforced.

Treatment by Private Practitioners.

> "'(*d*) Where treatment by private practitioners is adopted this should be done by means of a "School Centre," or in sparsely populated districts by the "recognition" of places (for example, a room in the school buildings) where the local practitioner or practitioners could carry out the necessary treatment.'

"The reasons given for the employment of private practitioners, as compared with whole-time school medical officers in the treatment of school children, are as follows:—

> "'1. The medical treatment of school children is a great national undertaking, the ultimate success of which largely depends upon the number of persons who are interested. From this point of view it is better that as many as possible of the medical profession should have personal contact with the work, rather than that familiarity with it should be confined to a small class of public officials.
>
> "'2. Medical practitioners who are engaged in private practice enjoy the benefit of a wider experience of the treatment of disease in general than those whose work is confined to the treatment (or the treatment and inspection) of school children.
>
> "'3. Treatment and recurrent supervision of the school children by such practitioners, supplemented by the "following up" work of the School Medical Officer, in the opinion of the Association, alone give security that the medical needs of the children will be adequately met.
>
> "'4. The treatment of diseases of children gives those who carry it out opportunities of obtaining valuable experience. If the work is done by private practitioners who are engaged, apart from their school work, in treating members of the general public, the general public derives great benefit from the profession generally receiving this additional experience.
>
> "'5. The employment of private practitioners gives the Education Authority a much wider field of choice than if the work is carried out by whole-time officers, and by the employment of part-time officers the authority would be able to adjust the appointment of persons of special skill to its requirements in each direction.'

"So that when Mr. Griffiths gives it as his mature opinion that the opposition to his scheme comes from only a very small minority of the profession, the value of his opinion is exposed. Not only does the home Association absolutely oppose a similar scheme there, but the resolution embodying the same views was carried unanimously by us at a largely attended meeting a fortnight ago.

"Hospital doctors are not, as have been alleged, refusing to treat children referred to them, except in cases where they are unable to detect the defects that have been reported.

"One other word and I have done. When a deputation from the British Medical Association waited on the Minister for Education, Mr. Pease (see *Supplement to British Medical Journal*, May 28, 1915, p. 545 *et seq.*), he was very sympathetic, and his attitude was in marked contrast to that of Mr. Griffiths. He sympathized with Dr. Finucane, the spokesman for the general practioner, and agreed that it must be a matter of some moment to practitioners when they felt that their own patients were being taken away to hospitals to be treated, instead of being treated in the ordinary way. He concluded his remarks by saying the present system, that is, treatment by a committee of practitioners at 'Medical Treatment Centres,' by arrangement with the voluntary hospitals (which is a very different thing from what Mr. Griffiths says is the same scheme as his, *viz.*, treatment by the inspecting doctor) should not be a permanent one, but that it should be gradually directed into lines which would meet with more general approval, and the Board was doing its very utmost to establish, by its influence, and he hoped, by tact those clinics in the various areas in London which the British Medical Association looked forward to see established." (Hear, hear.)

"I hope that the motion I have now the honour to submit to you will, like the one of a fortnight ago, be carried unanimously, as a complete answer to the Minister." (Prolonged applause.)

Dr. F. P. Sandes seconded the motion. In doing so he remarked that there was little necessity for him to add anything to what had been said by the proposer. No one could reasonably take any exception to Dr. Pockley's masterly address. He expressed the hope that the meeting would grasp the opportunity of educating the public on the dangers inherent in any scheme for the nationalization of the medical profession.

Dr. S. Sheldon congratulated the Council in their choice of proposer for the motions to be submitted to the meeting. Dr. Pockley had at last succeeded in demonstrating that there was a real need for resisting the attempts to deprive the medical profession of its freedom and individuality. He appeared to the meeting now as a champion of the rights of the profession. They must realize what they might expect, if the Government insisted in pressing their programme on the profession. It was essential to adhere rigidly to the resolutions, which he regarded as excellent. The members of the profession were ready and willing at all times to treat the public, but they set their face resolutely against the idea of according gratuitous treatment to persons who could afford to pay for it. He was of opinion that there

was no need to take much notice of the hot air of the Minister's utterances. He was a politician. He thought that the strong men of the profession should be urged to instruct him in regard to the actual state of affairs. When the Minister had their views properly before him, he would, no doubt, do his best to help them. He urged the meeting to leave the instruction of the Minister and of the public to the Council.

Dr. Sinclair Finlay bade the members be careful in attacking the Government. He held with Dr. Pockley that they were quite within their rights to carry out their ideas in regard to the practice of medicine. He hoped that members of the Branch would keep out of the press. After the case had been presented to the Minister properly, he would see the justness of their claims. He pleaded for unanimity to uphold the prestige of the profession which they all loved so well.

The Hon. J. B. Nash examined the terms of the motion, and found that the principle contained was sound. The British Medical Association differentiated between the inspection of school children and the treatment of the defects discovered at the inspection. The motions linked up the interests of the community with those of the profession. They had his hearty support.

Dr. R. E. Woolnough raised the question whether the motions before the meeting would embrace the men at present holding positions under the Department. Dr. Pockley had referred to the important work of following up the cases. He instanced one in which the inspector had discovered a visual defect, and had recommended glasses. He had advised the patient's parents to take the child to a specialist in Macquarie Street, where they would get the best treatment. They could afford to pay for it. He then learned that the nurse had suggested that the child should be taken to the Royal Prince Alfred Hospital, where the glasses would be supplied for 1s. He had no doubt that the nurse's advice had been followed.

Dr. Hugh G. Allen, of Newcastle, expressed his gratification at having been able to come from Newcastle to listen to the discussion. They were of one opinion that the medical inspection of school children was an excellent and necessary thing. Treatment was altogether different. He had come within recent times into more intimate contact with the Travelling Ophthalmic Clinic. The medical officers were prescribing glasses wholesale. A local optician had protested, because the parents had complained that the glasses made in accordance with the prescriptions of the ophthalmic officer did not suit the children. He had ascertained that the testing work was conducted at the rate of about one per minute. He held that the profession should do all it could to oppose practice of this kind. He recalled the remarks of his esteemed friend, Dr. Brady, that, despite his years of extended experience, he had yet a deal to learn. He was sure that the same applied to ophthalmic work. In the case of post-nasal growths, it was not easy to control the results, but in regard to defective vision, they had the glasses from which they could judge whether the work had been properly carried out or not.

Dr. A. J. Brady complimented Dr. Pockley on the able manner in which he had presented his case. He referred to the experience of the members of the staff of the Sydney Hospital. Several children were sent in by the inspectors for operation on post-nasal growths. On examination, it was found that there were no growths to remove. He insisted on the recognition that it was not easy to curette for adenoid vegetations. He had met cases in which the Eustachian cushion had been removed, presumably in mistake for a post-nasal growth. The result had been the sealing up of the tubes and consequent deafness. In hospital there were the best men for the special work required. These men had years of experience and an arduous training behind them. To become a specialist it was necessary first of all to pass through the ordinary curriculum of a medical student. In the next place, a hospital appointment should be held for one or two years. Then the practitioner would have to work in special clinics, and at the end of this time, it might be said that he had learned something of technique. Experience would come later. He asked what sort of men would be available for the appointments under the Department of Public Instruction. Would any medical man care to call in a young and inexperienced man in a really difficult case? It must be remembered that the medical officer would not have a senior man over him to correct his errors of diagnosis and to guide him in his treatment, as was the case in hospitals. At the Sydney Hospital, members of the staff were not allowed to operate until they had been in office for two years, unless they had had experience elsewhere.

What was Mr. Griffiths proposing to do for the children of the State? He would not obtain the services of leaders of the profession nor of any members of the British Medical Association. Was that in the interests of the children? Dr. Brady called attention to the threat that the Labour Ministry would make members meet men ineligible for membership of the Association. But perhaps the Labour Ministry might be replaced by a Liberal Ministry, and this action might influence the new Government to deal severely with trades unions. The privileged classes in Australia at the present moment were the trades unions, as long as the members were not attached to a profession.

Dr. George Watt expressed the approval of the members of the Western Medical Association of the action taken by the Branch, and supported the motions.

Dr. T. Linn O'Reilly wanted the discussion to appear in the public press, in order that the public might become aware of the reasons actuating the profession in adopting its present attitude.

Dr. Ralph Worrall held that the motions must be accepted, in view of the incontrovertible statement of Dr. Pockley. He thought that both Dr. Pockley's speech and the resolutions should be published together. So far, no reply had appeared to the Minister's utterances. He wished to add one more argument against the scheme of the Department. It was in his opinion one of the most powerful. The departmental officers would be required to deal with school children over wide districts, and would not know the children before they were called upon to inspect or treat them. Furthermore, these men would not have an opportunity of watching them afterwards, in the same manner as the family doctor could do.

Dr. E. Ludowici spoke of the gap in the treatment of school children. He maintained that the Department was forced to find some means of procuring treatment for the children found to be defective, since experience had shown that without this intervention, the children were left untreated. (Murmurs of emphatic dissent.) He urged the Council to confer with Mr. Griffiths for the purpose of attempting to find a mutually satisfactory solution of the difficulties.

In his reply, Dr. Pockley stated that he was doubtful whether the Minister had obtained the services of the kind of men he would have liked to have. In reply to Dr. Woolnough, he held that the wording of the motions was quite clear. It was held that the appointment of medical officers for the purpose of carrying out treatment of school children was inimical to the interests of the profession. That meant medical officers appointed at any time. Dr. Pockley thought that the remarks of Dr. Brady and of Dr. Allen were deserving of very careful consideration. He had been occupied at ophthalmic work for many years, but he could not do a refraction in one minute. He referred to his own experience, which showed that many of the children, for whom glasses were ordered, did not require them. Some opticians were honest enough to refuse to supply glasses of 0.25 D. This was the way in which the figures were exaggerated. He agreed that a conference with the Minister might be productive of good. In conclusion, Dr. Pockley expressed his gratification at the unanimity of the members present.

The question was then put, and the motion was carried unanimously.

An informal discussion took place on the suggestion that Dr. Pockley's address and the resolutions should be published in the daily press. The expression of opinion was voiced that it was greatly in the interests of the profession that members should refrain from contributing letters to the press on this matter. The members agreed that the task of bringing to the notice of the public the views of the profession should be left in the hands of the Council.

In the course of his remarks, Dr. Cyril Shepherd stated that the complaint of the medical branch of the Department of Education was that they could not get the children

treated. The inspectors found that the children required treatment, and when they were sent to hospitals, treatment as refused. In reality, the treatment was refused because defects requiring treatment could not be discovered.

It was resolved that Dr. Pockley's address and the resolutions should be handed to the public press for reproduction, in view of the fact that an undue delay would ensue if the publication were postponed until the next issue of *The Medical Journal of Australia*.

VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

Revenue and Expenditure Account for period from January 15, 1915, to January 13, 1916.

REVENUE.

	£ s. d.	£ s. d.
To Balance January 15, 1915		146 16 0
„ Subscriptions—		
Metropolitan Members	1,233 10 6	
Country Members	873 8 6	
Junior Members	78 9 9	
	£2,185 8 9	
Less refunds	5 8 6	
		2,180 0 3
Interest on Deposit Commonwealth Bank		1 15 0
		£2,328 11 3

EXPENDITURE.

	£ s. d.
By Medical Society of Victoria	1,205 13 6
„ British Medical Journal	829 8 3
„ Postages, Duty Stamps, Telegrams	24 14 7
„ Rebates to Divisions	57 0 0
„ Printing	30 18 6
„ Stationery	11 14 5
„ Commission (new members)	5 17 6
„ Clerical Assistance	7 17 9
„ Advertisement	4 16 0
„ Telephone Rent and Calls	4 11 2
„ Travelling Expenses (Secretary)	3 8 4
„ Auditor (1914)	3 3 0
„ Sundries	3 3 10
„ Bank Charges	7 7 3
„ Repairs—Furniture	1 9 10
„ Balance	127 7 4
	£2,328 11 3

LIABILITIES.

Nil.

	£ s. d.
To Balance as above	127 7 4
	£127 7 4

C. STANTON CROUCH, Secretary.
C. H. MOLLISON, Hon. Treasurer.

ASSETS.

	£ s. d.
Bank of Victoria, Ltd.	22 12 4
Cash in hand	3 0 0
Commonwealth Bank of Australia	31 15 0
Trustees Organisation Fund	70 0 0
	£127 7 4

Audited and found correct—J. V. M. WOOD and CO., F.I.A.V., F.C.P.A., Auditors.
Melbourne, 1st February, 1916.

MEDICAL SOCIETY OF VICTORIA.

Revenue and Expenditure Account for period from January 15, 1915, to January 13, 1916.

REVENUE.

	£ s. d.
To Balance January 15, 1915	210 2 7
„ Subscriptions	1,205 12 6
„ Sale of Assets, Australian Medical Journal	50 2 5
	£1,465 18 6

EXPENDITURE.

	£ s. d.	£ s. d.
By The Medical Journal of Australia	702 16 6	
„ Refund	0 10 6	
		703 7 0
„ Salaries—		
Secretary	335 16 8	
Library Clerk	36 0 0	
Caretaker	26 0 0	
		397 16 8
„ Library—Journals and Binding		25 9 10
„ Postages, etc.		25 0 0
„ Rates and Taxes		12 0 0
„ Rent of Safe Deposit		2 2 0
„ Lighting and Power		5 13 1
„ Audit for 1914		2 2 0
„ Bank Charges		0 11 0
„ Telephone		4 9 1
„ Trust Deed		2 2 0
„ Balance in Bank of Victoria		285 5 10
		£1,465 18 6

C. STANTON CROUCH, Secretary.
C. H. MOLLISON, Hon. Treasurer.

Audited and found correct—J. V. M. WOOD and CO., F.I.A.V., F.C.P.A., Auditors.
Melbourne, 1st February, 1916.

A meeting of the Victorian Branch was held at the Medical Society Hall, on February 2, 1916, Dr. R. L. McAdam, in the absence of the President, in the chair.

The Chairman extended a hearty welcome to Lieutenant-Colonel Harry W. Bryant and Lieutenant-Colonel George Horne, on their return from the front.

Lieutenant-Colonel Harry W. Bryant read a paper entitled "Notes on Difficulties and Trials of Administration of a Field Hospital."

Lieutenant-Colonel George Horne read a paper entitled "Experiences with the Australian Voluntary Hospital in France."

We propose to publish these two papers in a subsequent issue.

The Chairman accepted with thanks, on behalf of the Victorian Branch, a photograph of Anzac, enlarged from several small photographs taken by Major Mackworth, Director-General of the Signalling Corps (A.I.F.), at the Dardanelles. The photograph was the gift of Dr. J. Dunbar Hooper. He pointed out that the picture would hang in the Medical Society Hall as a memento of what had been appropriately termed the Westminster Abbey of Australia.

The Honorary Treasurer, Dr. Crawford H. Mollison, presented the annual accounts of the Victorian Branch and of the Medical Society of Victoria for the year 1915. The accounts had been duly audited. He pointed out that in order to learn the true financial position, the two balance sheets should be combined. It would be seen that the balance was £307 as compared with £253 of the previous year. It would thus appear that satisfactory progress had been made during the year. On the other hand, the £50 received as assets from the *Australian Medical Journal* would not recur, and if this were deducted, the increase would be reduced to £4. Further, there was still a sum of £96 owing to the Australasian Medical Publishing Company for Journals received by members, whose subscriptions had not so far been paid for the year 1915. When this had been paid there would be a loss on the year's transactions of approximately £50. This loss would recur annually, and was due wholly to the rate asked to be paid for the Journal, namely, 20s per member per annum, a sum much in excess of anything anticipated when the Journal was started. However, the Directors had strongly urged that it was necessary for the present to continue that rate, and as it was being paid by the other branches, the Council of the Victorian Branch had determined to continue the payment for the present, without prejudice to any action it might be found necessary to take later on.

The credit balance of the Branch and of the Society, which included money in the Commonwealth Savings Bank, amounted to £409. They would thus be able to stand the loss for a few years, but before it had disappeared entirely it was hoped that *The Medical Journal of Australia* would have established itself as a paying proposition, and would not require such a large subsidy from the Branches.

The report was adopted.

The following have been nominated for election to the New South Wales Branch:—

Dr. F. G. Connor, Sydney Street, Chatswood.
Dr. T. B. Clouston, Tumut.

Medical Matters in Parliament.

WESTERN AUSTRALIA.

AN ACT TO AMEND THE HEALTH ACT, 1911-12.

[*Assented to 8th December*, 1915.]

Be it enacted by the King's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and Legislative Assembly of Western Australia, in this present Parliament assembled, and by the authority of the same, as follows:—

1. This Act may be cited as the Health Act Amendment Act, 1915, and shall be read and construed as one with the Health Act, 1911 (hereinafter called the principal Act), and this Act and the Health Act, 1911-12, may be cited together as the Health Act, 1911-15.

2. Section three of the principal Act is hereby amended by inserting in its appropriate place the following definition:

"Venereal disease" means and includes gonorrhœa, syphilis (including congenital syphilis), soft chancre, venereal warts and granuloma.

3. The following Part is hereby inserted after Part IX. of the principal Act, that is to say:—

Part IX.—A.

Venereal Diseases and Disorders Affecting the Generative Organs.

242a. (1) No person other than a medical practitioner, or a person acting under the direct instructions of such a practitioner, shall attend upon or prescribe for any person suffering from any venereal disease for the purpose of curing, alleviating or treating such disease.

Penalty: Fifty pounds, or six months imprisonment with hard labour.

(2) The preceding subsection shall not apply to a registered pharmaceutical chemist who dispenses to the patient of a medical practitioner the prescription of such practitioner *or to a registered pharmaceutical chemist who sells* or any person who, under a permit in writing from the Commissioner (which permit the Commissioner is hereby empowered to grant) sells to any person any patent or proprietary medicine (as defined in section one hundred and eighty-seven of this Act) for the cure or alleviation of any venereal disease, from which such person is suffering: Provided always that such medicine is one that has been approved by the Commissioner as fit to be sold for the cure or alleviation of such disease.

Nor shall the preceding subsection apply to the sale by a registered pharmaceutical chemist in the ordinary course of business of any drug, not being a patent or proprietary medicine which has been approved as aforesaid, and not being prescribed by him for the cure or alleviation of any venereal disease.

Provided that a permit as aforesaid shall not be granted to any person other than a pharmaceutical chemist unless no pharmaceutical chemist carries on business within ten miles of the place of business of such person.

242b. (1) Every person suffering from any venereal disease shall, within three days of his becoming aware or suspecting that he is so suffering, consult a medical practitioner thereon and place himself under treatment by such practitioner.

Penalty: Twenty pounds.

(2) On any prosecution under this section it shall be a defence if the defendant shall prove—

(i.) that he never was, within the period of three days, within twenty miles of a medical practitioner; and

(ii.) that he did within such period consult such a practitioner by letter, and has followed, so far as possible, any advice given by the practitioner.

Provided that such proof shall afford no defence if it appears that at any time before the complaint was laid the condition set out in paragraph (i) hereof has ceased to apply to the defendant, and he has not thereupon personally consulted and placed himself under treatment by a medical practitioner.

242c. (1) Every person suffering from a venereal disease who has consulted and placed himself under treatment by a medical practitioner shall (until he has received a certificate of cure) personally attend or cause himself to be attended by a medical practitioner for the purpose of treatment and advice at least once in every four weeks, and shall follow, as far as possible, the advice given by any such practitioner.

Penalty: Twenty pounds.

(2) If any such person shall at any time decide to change his medical adviser, or if the medical adviser of such person shall die, or for any reason be unable or unwilling to attend him further, then such person shall forthwith consult and place himself under the treatment of another medical practitioner, and immediately

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The words printed in italics have been added as amendments of the original Bill. The words deleted from the Bill are not shown.

after doing so shall inform his new adviser of the name and address of his last previous adviser, and the medical adviser so informed shall thereupon send a notification in the prescribed form of the change made by the patient to such previous adviser, if such adviser be living and in the State.

Penalty: Five pounds.

242d. Every medical practitioner shall forthwith give notice to the Commissioner in the prescribed form upon becoming aware that any person attended or treated by him is suffering from any venereal disease *in an infectious stage*. The notice shall state the age and sex of the patient and the nature of the disease, but shall omit the patient's name and address.

Penalty: *Five pounds.*

242e. If any patient who has been attended or treated by a medical practitioner for a venereal disease *in an infectious stage* shall fail to consult or attend such practitioner for a period of six weeks, and the practitioner shall not within that period have received from another practitioner a notice that the patient has changed his medical adviser, then such firstmentioned practitioner shall send to the Commissioner, in the prescribed form, a notice of the facts, stating the name and address of the patient.

Penalty: *Five pounds.*

242f. Every medical practitioner who attends or advises any patient for or in respect of any venereal disease *in an infectious stage* from which the patient is suffering, shall, by written notice delivered to the patient, direct such patient's attention to the contagious character of the disease, and to the legal consequences of infecting others, and shall by such notice warn the patient against contracting any marriage until he is certified as cured.

Penalty: Five pounds.

242g. When any such patient as aforesaid shall become cured of the disease, any medical practitioner shall, on being satisfied of the fact, give such patient a certificate of cure in the prescribed form.

242h. *The Commissioner shall conduct free of charge bacteriological or other examination which is required by any medical practitioner who has notified the Commissioner under Section 242 (d) that he is attending or treating a person suffering from venereal disease.*

242i. (1) When any person under the age of sixteen years is or becomes liable under this part of this Act to do or submit to any act, matter, or thing, any parent or guardian of such person, who knows that such person is so liable, shall exercise his authority and use his best endeavours to compel or induce such person to do or submit to such act, matter, or thing as aforesaid.

Penalty: Ten pounds.

(2) Any parent or guardian of any such person as aforesaid who knows that such person has failed to comply with any provision of this Act with which he ought to have complied, shall report the fact to the Commissioner.

Penalty: Ten pounds.

242j. (1) *Whenever the Commissioner has received a signed statement, in which shall be set forth the full name and address of the informant, stating that any person is suffering from venereal disease, and* whenever the Commissioner has reason to believe that *such* person is suffering from *such* disease, *he may give notice, in writing, to such person, requiring him to consult a medical practitioner, and to produce to the satisfaction of the Commissioner, within a time to be specified in the notice, a certificate of such medical practitioner that such person is or is not suffering from the disease, and if such certificate is not produced within the time stated in such notice, or if the Commissioner be not satisfied with such certificate* he may, by warrant under his hand, authorize any medical officer of health or any two medical practitioners to examine such person to ascertain whether such person is suffering from such disease, and the said officer or practitioners shall have power to examine the person accordingly, and shall report the result of his or their examination to the Commissioner in writing.

Provided that where the person to be examined is a female, and the examination is to be by two medical practitioners, one of such practitioners shall, if so desired by the person to be examined, be a female medical practitioner, if able and willing to act, and within twenty miles of the place where the examination is to be made.

(2) If the report discloses that the person is suffering from any venereal disease *in an infectious stage, and is, in the opinion of the Commissioner, likely, unless detained, to infect other persons,* the Commissioner may, by warrant under his hand in the prescribed form, and directed to the prescribed persons, order the person to be apprehended, and to be detained for any period not exceeding two weeks in any hospital or other place, and the Commissioner may by such warrant order any bacteriological and other examinations and investigations to be made of and in respect of such person.

(3) If after such detention it shall appear to the Commissioner that the person is suffering from any venereal disease in an infectious condition, *and that further detention is necessary in the interests of the public, and so reports to the Governor,* then it shall be lawful for the Governor, at any time and from time to time on the recommendation of the Commissioner, to issue his warrant in such form, and directed to such persons as he shall think fit, authorizing and requiring the apprehension of such person and the detention of such person in such place for such time as the Governor may think fit, and the Governor may by any such warrant direct that such person shall be subject to any treatment and examination which the Governor may, on the recommendation of the Commissioner, think necessary in the circumstances.

(4) When any person is subject to detention under this section *he may from time to time apply in writing to a judge of the Supreme Court or a resident or police magistrate in the district in which he is detained to be examined by two medical practitioners,* and thereupon *such* judge or magistrate *shall* by order direct any two *or more* medical practitioners named in the order, *one of whom shall be nominated by the patient or some person on his behalf,* to examine such person *accordingly* and report the result of the examination to the judge or magistrate, and every officer or authority in whose custody the person is shall permit the examination. If it appears from *such* report that *all the medical practitioners are unanimously of opinion that* the person is cured or *is* free from venereal disease, *or if such report discloses that the person is suffering from venereal disease in an infectious stage, but the Commissioner fails to satisfy the judge or magistrate that the person would be likely to infect others unless detained,* then the judge or magistrate *shall* order the release of such person, *who* shall be liberated from detention accordingly; *provided that no application shall be made by a person so detained within six calendar months of a prior application having been made by such person.*

(5) *When any person is subject to examination or detention under the provisions of this section, and is found not to be suffering from venereal disease or to be suffering from venereal disease, but not in an infectious stage, or to be suffering from venereal disease in an infectious stage, but not likely to infect others he shall be entitled as of right to inspect any written statement made to the Commissioner under Subsection* (1) *of this section, and to have a verified copy of every such statement.*

(6) This section shall apply to any person undergoing imprisonment, but except in so far as is necessary in order to carry into effect the provisions of this section, the sentence of imprisonment shall not be interfered with; provided that the period of any detention suffered hereunder shall be reckoned as part of the term of imprisonment. If the person still remains liable to serve any portion of the term of imprisonment at the termination of the detention hereunder, the Minister may issue his order to any police officer, directing him to convey the person to the gaol or prison where such person is liable to complete the sentence.

(7) Every warrant issued hereunder may authorize the use of such force as may be necessary to carry it

into complete effect, and shall have effect according to its tenor, and all police officers shall on sight of the warrant aid and assist in its execution in so far as they may be requested so to do by any person to whom the warrant is directed.

(8) Any person who contravenes any provision of this section by act or omission or obstructs the carrying into effect of any warrant or order issued thereunder, or refuses to do or submit to anything which such person is by this section, or any such warrant or order, required to do or submit to, shall be guilty of an offence against this Act.

Penalty: Twenty pounds.

242k. No person shall knowingly infect any other person with a venereal disease or knowingly do or suffer any act likely to lead to the infection of any other person with such a disease.

Penalty: Fifty pounds, or imprisonment with hard labour for six months.

242l. (1) The persons having the management or control of any hospital which has received in any financial year a subsidy from the State shall make effective provision for the examination and treatment free of charge, in accordance with regulations made by the Governor (pursuant to the power which is hereby conferred upon him) of such persons or classes of persons suffering from venereal disease as the Governor may by such regulations declare fit to be treated at or by such hospital.

In case default is made in compliance with this subsection, the Colonial Treasurer may withhold from such hospital the whole or any portion of any subsidy which would be payable thereto during the next financial year.

(2) Every medical practitioner in receipt of any salary from the State shall examine and treat free of charge *to such person* any person suffering from venereal disease who shall apply to him for examination and treatment.

And the Commissioner shall pay a reasonable remuneration for such examination and treatment, and shall be liable to be sued for such remuneration in any court of competent jurisdiction.

Any medical practitioner who neglects or refuses to examine or treat any person, as provided by this subsection, shall be liable to a penalty not exceeding £5.

242m. *All proceedings under sections 242a, 242b, 242c, 242d, 242e, 242f, 242i, 242j, 242k, in any court shall be heard in camera; and it shall be unlawful to publish in any newspaper a report of any such proceedings.*

Penalty: For a first offence, One hundred pounds, or imprisonment with or without hard labour for not exceeding six months; for any subsequent offence, five hundred pounds, or imprisonment with or without hard labour for not exceeding twelve months.

242n. (1) No person shall publish any statement which is intended by such person or any other person to promote the sale of any article as a medicine, instrument, or appliance, for the alleviation or cure of any venereal disease or disease affecting the generative organs or functions, or of sexual impotence, or of any complaint or infirmity arising from or relating to sexual intercourse or of female or menstrual irregularities.

(2) Any person who—

(a) so affixes or inscribes any statement on anything whatsoever that it is visible to persons being in or passing along any street, road, highway, railway or public place; or

(b) delivers or offers or exhibits any statement to any person being in or passing along any street, road, highway, pathway, public place or public conveyance; or

(c) throws any statement down the area or into the yard, garden or enclosure of any house; or

(d) exhibits any statement to public view in any house, shop or place; or

(e) prints or publishes any statement in any newspaper; or

(f) sells, offers, or shows *or sends by post* any statement to any person, shall be deemed to have published that statement.

(3) The word "statement" includes any document, book or paper containing any statement.

(4) Books, documents and papers published in good faith for the advancement of medical or surgical science are exempt from the provisions of this section.

(5) Any contravention of this section shall be an offence against this Act.

(6) *Before any proceedings are taken under this section against any newspaper proprietor, printer, or publisher for printing or publishing any statement in a newspaper, the Commissioner shall notify the proprietor, printer, and publisher of such newspaper that the publication of the matter complained of is an infringement of this part of this Act; and such proprietor, printer, and publisher shall not be liable to prosecution for an offence against this section, except in respect of an offence of the same or a similar nature after such notification.*

242o. *Every person employed in the administration of this part of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment, and shall not communicate any such matter to any other person except in the performance of his duties under this Act.*

Penalty: One hundred pounds.

242p. *So far as personal service of any notice is required under the provisions of this part of this Act, such service shall be effected by an officer of public health.*

4. The following section is hereby added to the principal Act:—

301. All courts and magistrates shall take judicial notice of all by-laws and regulations made under this Act.

5. All copies of the Health Act, 1911-12, hereinafter printed by the Government Printer shall be printed as amended by this Act under the supervision of the Clerk of Parliaments, and all necessary references to this Act made in the margin, and in any such reprint the short title shall be the Health Act, 1911-15.

Special Correspondence.

(By our Special Correspondent.)

LONDON LETTER.

King Edward's Hospital Fund.

The statistical report of King Edward's Hospital Fund for 1914 was issued on October 12, 1915. The hospitals with which the report is concerned number 108, and, taken together, provided a total average of 8,963 beds in daily occupation throughout the year. The total number of in-patients admitted was 134,025, while 1,321,104 patients attended at the out-patient departments. The total ordinary expenditure during the twelve months, including maintenance, administration, rent, rates, and taxes, but excluding capital expenditure and interest on borrowed money, amounted to £1,081,162. The expenditure shows a small increase over that of the preceding year, while, on the other hand, the number of available beds was slightly reduced, and the patients treated are somewhat fewer. Among the in-patients treated during the year are included 5,478 naval or military patients (chiefly wounded soldiers), being the number admitted by understanding with the authorities during the last few months of 1914. A very much larger number of such patients are being treated in the London voluntary hospitals during the year 1915. The wholly exceptional circumstances under which the London hospitals had to carry on their work during the closing part of 1914 would render comparisons with previous years of little value. The cost of working was affected in hospitals generally by the rise in prices and the difficulties created by the departure for military and Red Cross duties of members of the medical, nursing, and administrative staffs; while at many hospitals the number of occupied beds was affected either by beds being added for the use of the wounded or by beds being kept vacant in readiness for their accommodation at short notice. After careful consideration of the exceptional circumstances of the latter part of the year 1914, it has been decided to omit, on this occasion, all comparisons with previous years. The cost per bed at each hospital, however, is given, and the aver-

age for each group. The governing body of each hospital can thus see by comparison with previous reports what the increase of cost has been. It is hardly necessary to add, the honorary secretaries remark, that at a time when, as at present, exceptional circumstances have occasioned considerable increase in the cost of working, the necessity of preventing any increase that can be avoided is more than ever urgent, and the expenditure at the London hospitals, where a high standard of efficiency is essential, and is generally attained, will, it is felt, be carefully controlled, and will continue to receive the attentive consideration of the Fund.

Vivisection Returns for 1914.

From a Home office return issued on October 12, 1915, it appears that 678 persons in England and Scotland held licenses in 1914 to experiment on living animals. Of that number 188 performed no experiments. The number of experiments other than those of the nature of "simple inoculations, hypodermic injections, or similar proceedings" was 4,889, a decrease of 1,460, while inoculations and injections without anæsthetics numbered 82,364, an increase of 555. The total number of experiments was 87,253, being 905 fewer than in 1913. During the year 22,371 experiments were performed by 19 licensees in the course of cancer investigations. More than 24,000 experiments were performed by 94 licensees for Government Departments and public authorities. A large number of experiments were witnessed at the registered places by the inspectors, the visits for the most part having been made without previous notice. The inspectors report that they found the animals suitably lodged and well cared for, and the licensees generally attentive to the requirements of the Act and the conditions attached to their licenses by the Secretary of State.

Lectureship in Pathology.

The Commercial Union Assurance Company, acting as Trustees and Executors of the will of the late Sir William Dunn, have handed to the Governors of Guy's Hospital Medical School £25,000 in new War Loan 4½%, fully-paid stock, for the purpose of endowing a Lectureship in Pathology in the Medical School, to be called "The Sir William Dunn Lectureship in Pathology." It is believed that this will be the most liberally endowed Lectureship in Pathology in Great Britain.

Correspondence.

THE HEALTH ACT OF WESTERN AUSTRALIA.

Sir,—The writer of your leading article in your issue of January 29th has fallen into a few pitfalls concerning the scope of this Act. This is, no doubt, due to the impression gained from a perusal of the drastic Bill as introduced, and a failure to recognize the effect of the important amendments passed by the Legislative Council, and finally adopted by the Assembly. As one who bore some part in getting these amendments passed in the Legislative Council, may I point out the errors into which the writer has fallen, and I would ask anyone interested in this legislation to study the Act as passed, and not the Bill as originally introduced.

Your article states "no provision is made for any appeal from the decisions of the Commissioner." This is erroneous. Section 242j (4) gives power of appeal to a resident magistrate or judge, who shall thereupon order examination by two or more medical men, one of whom shall be nominated by the patient. If the report reveals that he is not suffering from the disease, or if the Commissioner fails to satisfy the judge or magistrate that the person would be likely to infect others unless detained, then the judge or magistrate shall order the release of such person.

I would like to draw the attention of your readers to the words "the Commissioner must satisfy the judge or magistrate that the person is likely to infect others." The onus of proof is put on the Commissioner to show that the person is likely to infect others. Not every person suffering from venereal disease is likely to infect others, and, consequently, only the person who carelessly or wilfully infects others can be caught in the meshes of this net. This is quite different to the interpretation of the Act given in another portion of your article that the person is to be detained "until it can be proved that the person is no longer in a condition to infect others." Such a view is not borne out by a perusal of the Act.

It cannot be too strongly pointed out that the objects of the Act are (1) to compel patients to seek properly qualified medical advice and to suppress the quack, and (2) to detain and treat in a hospital the man or woman who wilfully or carelessly infects others.

The public are safeguarded from the anonymous and malicious informer by the fact that the Commissioner can only act on a written and signed statement, and that a person wrongly accused is entitled to inspect and obtain a copy of the statement.

No doubt experience may suggest modifications, but the measure, as passed, was fully debated, and every detail threshed out in the Legislative Council, and all the amendments which the Council inserted were adopted by the Assembly before the measure finally became law.

Yours, etc.,

ATHELSTAN SAW, M.D., M.L.C.

Wentworth Hotel, Sydney,
January 30, 1916.

THE B.M.A. AND THE GOVERNMENT OF NEW SOUTH WALES.

Sir,—The vagaries of the B.M.A., of which I am an unworthy member, always give me an intense joy.

But why all this potter about a simple little experiment in socialistic legislation? Surely we are already as a people inured to such experiments generally. Why buck at them when they affect us, or may possibly affect us professionally? If the project is in itself a good one, it will succeed; if bad it is already doomed to failure, and the taxpayer or the children alone should wail.

There is one point of view—the main one, as noted by the B.M.A.—on which I should like to comment, and that is the B.M.A.'s objection to the treatment by Government officials of children, whose parents can afford to pay for such treatment.

This is purely a political pretext, not a professional one. The Government proposes to pay the doctors employed, and it seems to me to be just a little invidious, a little undignified, shall I say, to squeal, because eight or a dozen presumably respectable medical men are going to get comfortable incomes at the loss of a few fees per head to the rest of the profession, and I feel quite sure the fees lost will only be few. At any rate, let us be fair and admit that the work is to be paid for, even if it is by the Government, and personally I do not think that I worry very much who pays my own patients' fees, so long as they are paid, and I do not believe that any other member of the B.M.A. cares much either. I simply want to point out that the B.M.A.'s protest is a political, not a professional one.

To come to the Government's point of view, I feel still greater joy, in the contemplation of the scheme, and of its practical working. I visualize the arrival of the two Government officers, not forgetting the Government nurse, in a town such as I grace with my presence, the subsequent yarding of the children, or would this be done the night prior to their arrival, with strict precautions against the victims obtaining solid food. What about stragglers? obtaining suitable accommodation for operating, or would the school suffice? A general round-up for shearing would be child's play to it; I feel sure that to clean up this little district alone would take very nearly a week, and there are 414 schools of the same class (IV.), averaging from 50 to 199 pupils, and 552 in class II., averaging 50 to 30 pupils, and over 3,000 schools in all. Teutonic organization, with compulsory removal of all adenoids and offending tonsils seems inevitable, with possibly circumcision thrown in for variety's sake.

I also strive to imagine the mental condition after, say, two years, of the eight or twelve gentlemen who are doomed to a perpetual cycle of this soul-inspiring work; lamb-marking were less monotonous, yet, I venture to say that the most enthusiastic breeder of sheep would grow weary of so perpetual a feast; an eternal banquet of tonsils, with post-nasal vegetations, should satiate very soon.

To sum up, I do not think the profession has much to fear from the project; if it fails, so be it; if it is successful, it will do little or no harm to the profession, as compared to the good it may do for the community, and I think we should always remember that our profession, like the Sabbath, was made for the people, not the people for the profession.

Yours, etc.,

H. S. MAW.

January 23, 1916.

THE TRAVELLING HOSPITAL.

Sir,—In *The Medical Journal of Australia* of the 5th inst. you quote from, and make comments on, my annual report for 1914. I desire to take exception to one of your comments, owing to its inaccuracy and the unfair implication contained therein. In the last paragraph of page 126 there appears the following about the Department's Travelling Hospital: "The Principal Medical Officer makes the following statement, 'This Hospital works in those parts of the State where there are no resident doctors or dentists.'" Commenting on this you state: "On reference to the maps (connected with the report) it is seen that the Travelling Hospital visited the following places: Wagga Wagga, Henty, Tumbarumba, Corowa, Germanton."

Now, with the single exception of Germanton, none of these places were visited by the Travelling Hospital. If reference be made to the map, it will be found difficult to understand how such a mistake could have been made, seeing the scale the map must have been drawn to represent a State with an area of some 310,000 square miles. It is especially difficult to understand the mistake in the case of Wagga Wagga and Tumbarumba. The map shows (*a*) in the case of Wagga, the place visited as miles from the railway on which Wagga is situated, and (*b*) in the case of Tumbarumba, the place visited as miles from the circle representing the township.

As far as Germanton is concerned, the only treatment carried out was that given by the ophthalmic surgeon, who, for the time being, took the place of the Ophthalmic Clinic.

Yours, etc.,

C. SAVILL WILLIS,
Principal Medical Officer.

Department of Public Instruction, N.S.W.,
Medical Branch, Sydney,
8th February, 1916.

[It is unfortunate that the Principal Medical Officer did not state in the body of his report the exact positions visited by the Travelling Hospital. Reference to the map shows: (1) That the area containing Wagga Wagga, Germanton, etc., measures approximately 70 miles from north to south and 56 miles from east to west. The rectangle, as printed in the map, measures 29 mm. by 24 mm. (2) The signs used for the places visited by the Travelling Hospital and the Travelling Ophthalmic Clinic measure approximately 3 mm. in diameter. The signs therefore cover an area equivalent to about 7 miles. (3) Within the area there are 14 signs, indicating places visited by the Travelling Hospital and 3 indicating places visited by the Ophthalmic Clinic. One sign actually touches the circle representing Tumbarumba, and another is printed in the word Wagga Wagga. In regard to Corowa, the signs for the Travelling Hospital and the Ophthalmic Clinic are partially overlapping one another, and certainly appear as if they cover the township. We therefore claim that reference to the map justifies the conclusions drawn.]

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—New Appointments as Medical Officer, Ophthalmic Surgeon, Ear, Nose and Throat Surgeon, Physician. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Mudgee (except A.H.C.G., M.U.I.O.O.F., U.A.O.D., and P.A.F.S.). F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith and Auburn. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute. Croydon Hospital. Laidley Hospital, Medical Officer.
NEW ZEALAND: WELLINGTON DIVISION. Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

Feb. 15.—N.S.W. Branch, Executive and Finance Committee, Ethics Committee.
Feb. 16.—W. Aust. Branch, B.M.A., General.
Feb. 23.—Vict. Branch, B.M.A., Council.
Feb. 24.—S. Aust. Branch, B.M.A., General.
Feb. 29.—N.S.W. Branch, Medical Politics Committee, Organization and Science Committee.
Mar. 1.—Vic. Branch, B.M.A., Branch.
Mar. 3.—Queensland Branch, B.M.A., Branch.
Mar. 8.—South Sydney Med. Assoc. (N.S.W.), Annual.
Mar. 9.—Vic. Branch, B.M.A., Council.
Mar. 10.—South Aust. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

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